PROJECT CONCERN INTERNATIONAL

FINAL EVALUATION REPORT

June 21 - July 2, 1994

CHILD **SURVIVAL** VII:

Expanding the Community's Role in Child Survival
Through ***Posyandu*** Supervision Teams and NGO Development

RIAU PROVINCE, INDONESIA

September 1, 1991 - September 30, 1994

Implemented by:

Project Concern International
and
Ministry of Health, Riau

Evaluation Team:

Tanya Inalot Mokoginta, MD
Mansyur Pawata, SH
Jeffrey Billings, MPH, MIA

Project Director:

Abdul **Manan,** MD, MPH

Project Concern International
3550 **Afton** Road, San Diego, California 92123
Telephone: (619) 279-9690 Fax: (619) 694-0294

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APPENDICES:

LIST OF TERMS

BangDes	Village Development Office
Bidan Desa	Village Midwives
BKKBN	National Family Planning Board
EPI	Expanded Program for Immunization
Kader	Community health volunteer
KMS	Maternal Health Card
MOH	Ministry of Health
NGO	Non-Governmental Organization (Indonesian)
PKK	Women's Family Welfare Organization
PPAS	School Posyandu Program
PST	Posyandu Supervisory Team
Posyandu	Integrated village health post
PVO	Private Voluntary Organization (American or international)
RR1	Radio of the Republic of Indonesia
TBA	Traditional Birth Attendant

INTRODUCTION

Project Concern International (PCI) has been involved in health and development activities in Indonesia for over twenty years. In 1984, PC1 was asked to work in Riau by the Secretary of the Directorate General of Community Health as the province had received no assistance from the non-governmental sector, and as the Provincial Ministry of Health had been facing difficulties in reaching all of the population with adequate child survival services. PC1 entered this province in 1989, during the second half of PCI's Child Survival IV project (CS-IV). The Child Survival VII Project discussed in this report attempted to build on the activities of the CS-IV Project through focussing on improving *Posyandu* implementation and attendance, through strengthening *Posyandu* Supervisory Team structures, and through training TBAs and utilizing supportive social marketing schemes.

As part of the Child Survival grants program, USAID requires that each recipient organization (PVO) conduct a final project evaluation. The purpose of the evaluation is to assess the level of accomplishment the organization has achieved during the life of the project, and the prospects for sustainability. This assessment allows USAID to determine how effectively its funds have been used, and allows the PVO and its counterparts to learn valuable lessons which can be applied to future child health programs.

PC1 worked in partnership with the Riau Ministry of Health to implement the CS-VII project, rather than operating alone. PCI's role was primarily to train personnel and to facilitate the development and functioning of systems for health delivery and support. So it is often difficult to assess the results of PCI's work versus the work of the MOH and other counterparts. This report will focus on those objectives and activities which were specifically the responsibility of PCI, as laid out in the DIP.

The final evaluation was conducted from June 21 to July 2, 1994 by an evaluation team selected by PCI. The team members included Dr. Tanya Inalot Mokoginta from the Directorate of Community Participation, MOH/Jakarta; Mr. Mansyur Pawata, the Director of SINTESA, an Indonesian NGO based in S.E. Sulawesi; and Mr. Jeffrey Billings from PC1 headquarters. The evaluation methodology involved conducting interviews with MOH officials, local government leaders, health center staff, TBAs, *kaders*, teachers, students and PST members in two of the four project districts.

Also included are the results of the project's final survey, conducted in May by the staff of PCI/Riau. The survey utilized the 30-cluster methodology and the standard KPC questionnaire. (The complete survey report can be found in Appendix 2.)

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomulishments

Al-A3. The overall goal of the CS-VII project was to decrease infant and child morbidity and mortality in the Province of Riau. Toward this end, 12 specific project objectives were adopted. Following is a list of these objectives, a statement of the level of accomplishment for each, and a description of circumstances which aided or hindered the project in meeting the objectives.

1. Increase to 40% the proportion of children between 12 and 24 months who were fully immunized by 12 months of age. (Baseline: 19%)

The final project survey (30 cluster sample survey) found 37% complete coverage. The first immunization contact was found to be high (BCG was 54%), but the drop-out rate was also high, causing a lower-than-expected complete coverage rate.

2. Increase to 65% the proportion of mothers of children under two years of age whose most recent delivery was fully protected from tetanus. (Baseline: 37% taken from the Provincial MOH Health Profile of 1990; CS-VII baseline survey was unable to obtain this data.)

   The final project survey found that 12% of mothers interviewed had received two doses of TT vaccine (29/239). It is difficult to accurately determine the TT coverage rate, because very few women possess a KMS card. The MOH began the campaign to distribute and use the KMS card in 1991. Although PC1 has printed enough cards for the mothers, most of them are still not distributed to all villages in the project area.

3. Increase to 35% the ORT use rate (the proportion of children under two whose episode of diarrhea within the last two weeks was treated with ORT (Or-alit). (Baseline: 28%)

   The final survey found an ORT use rate of 46%. In the surveys carried out for this project, "ORT' was considered to include only treatment with Oralit. Treatment with sugar and salt solution (SSS) was considered to be "ORS".

4. Increase to 50% the ORS use rate (the proportion of children under two whose episode of diarrhea within the last two weeks was treated with ORS (SSS). (Baseline: 19%)

   The final survey found an ORS use rate of 11%. This includes only those children treated with sugar and salt solution (SSS). The promotion of SSS for treatment of diarrhea1 dehydration has declined in Indonesia due to the World Health Organization's recommendation that it not be emphasized.

5. Increase to 35% the proportion of children under two whose episode of diarrhea within the last two weeks was treated with correct dietary management. (Baseline: More breastmilk than usual: 14%; more fluids than usual: 28%)

   According to the final survey, 26% of these children were treated with more breastmilk than usual, and 35% with more fluids than usual.

6. Increase to 35% the proportion of children under two who were breastfed within the first eight hours after delivery. (Baseline: 27%)

   The final survey found that 39% of mothers of children under two reported that they breastfed their babies within eight hours after delivery.

7. Increase to 40% the proportion of children under two who were exclusively breastfed until at least four months. (Baseline: 25%)

   The final survey found that 31% of these children were exclusively breastfed until at least four months of age. The target of 40% was probably too high for Riau Province. The national target is 40%, and the current national coverage figure is approximately 30%.

8. Increase to 75% the proportion of mothers of children under two who received at least two pre-natal exams during their most recent pregnancy. (This objective was assessed by examining only those mothers who posessed a maternal health (KMS) card. Baseline: 100% of women holding a KMS card had received two pre-natal exams, but there were only two such women.)

According to the final survey, 79% (19 of 24) of the mothers holding a KMS card had received at least two prenatal exams. However, only 10% of all mothers interviewed had a KMS card. A further 12% said they previously had a card but lost it. As stated above, measurments of this kind are difficult due to the lack of KMS cards in the villages.

Self-report method: A total of 175 mothers (73%) stated that they visited a health facility for pre-natal care during their last pregnancy. However, the mothers were not asked how many pre-natal care visits they had made.

9. Increase to 80% the proportion of mothers of children under two whose most recent delivery was attended by a trained TBA. (Baseline: 65%)

The final survey found that the deliveries of 75% of the mothers had been attended by a trained assistant (TBA or more highly-trained health worker). More specifically, half of the mothers (50%) were attended by a trained TBA; 25% by a health professional (physician, nurse or midwife); 22% by an un-trained TBA; and the remainder by family members or by themselves.

10. Increase the contraceptive prevalence rate to 50%. (Baseline: 47%) The Detailed Implementation Plan does not define the term "contraceptive prevalence rate", and many interpretations are possible. This evaluation report uses the standard "Modem Contraceptive Usage" indicator, as defined by the Child Survival Support Program, to measure the baseline and final rates.

The final survey found that the percent of mothers who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method was 51% (88 of 174).

11. Increase to 85% the proportion of children under two being fed vitamin A-rich foods. (Baseline: 65%. The baseline proportion of 79%, as reported in the DIP, was an error.)

The final survey found that 76% of children under two were being fed vitamin A-rich foods. The target for this objective should have been set lower than 85%. In this case, the figure of 85% was chosen because of the erroneous baseline proportion, as well as the fact that the target established by the MOH for vitamin A consumption in Riau province was 85%.

12. Increase to 50% the proportion of children between 18 and 23 months of age (KMS holders only) who have received semi-annual prophylactic vitamin A. (Baseline: 14%. The DIP was incorrect in stating the baseline proportion as 23%.)

According to the final survey, 22% of these children have received semi-annual vitamin A. The target of 50%, which was set by the MOH for the entire province and adopted by PC1

for the CS-VII project, was unrealistically high. Health center staff were not able to regularly visit the more remote *Posyandu* in Riau to distribute vitamin A capsules.

A4. Under a grant from the Riau MOH, Utama conducted the first province-wide IMR/MMR survey ever attempted in Riau. An important factor in the selection of Utama for this assignment was the experience they had gained with PC1 on the Child Survival projects. And the survey further raised Utama's professional reputation in Riau. Utama implemented the IMR/MMR survey with its own staff, and contracted with some PC1 staff to assist them. An unanticipated benefit of this activity was that Utama/PCI staff were able to monitor certain CS-VII project sites during field visits for the survey. This expanded the effective resources available for field supervision. Utama staff were also able to improve their skills in survey methods and computerized data analysis.

A5. The report of the project's final survey and the results for each relevant indicator are included in Appendix 2.

B. **Project** Expenditures

Bl. The final pipeline analysis is included in Appendix 1.

B2. The total USAID portion of the Riau budget was $475,372, and total expenditures for the project amounted to $527,832. For the PC1 match portion, the total budget was $156,215, and total expenditures reached $1,281,519. Thus the project over-spent the USAID budget by $52,460, and the PC1 budget by $1,125,304. Several budget categories were also either over-spent or under-spent, including Consultants, Travel/Per Diem, Equipment, Supplies and Other Direct Costs.

B3. The above discrepancies were due in part to the fact that, during the period of the CS-VII grant, PCI's financial monitoring system was not sophisticated enough to adequately track expenditures versus budgets. And the CS-VII grant was monitored as a single account, rather than by project site (Other CS-VII project sites--namely, Maluku Province, Indonesia; Guatemala; Nicaragua; Bolivia and PCI/Headquarters--were also either over- or under-spent against their USAID and PC1 budgets.).

During 1994, PC1 has been extensively restructuring its fmancial system, under the leadership of a new Chief Financial Officer. PC1 has developed a financial reporting and analysis system which allows headquarters-based staff members to monitor revenue and expenditures for each project site and cost center, by means of monthly financial reports and reviews of revenue and expenditure statements against budgets. This new system should allow PC1 to closely monitor future grants, and avoid some of the problems mentioned above.

B4. When budgeting for a Child Survival project, it is important that all potential sources of revenue be included, and that project staff do not commit to activities that require resources not available to the project. In particular, some activities require unrestricted cash, while others can more readily be supported with in-kind inputs. Since PVOs are permitted to credit in-kind inputs toward the required 25% match, it should be expected that they will do so, as is quite evident above. And, in many cases, unrestricted cash resources will be contributed only when absolutely necessary, and only if available. Project managers must have a realistic expectation of how much cash they will

receive, and should be prepared to reduce project objectives and cut back planned outputs if necessary.

C. Lessons Learned

Cl. *Posyandu* SUPERVISORY TEAMS **(PSTs)**

Cla. General

Posyandu Supervisory Teams (PST) are groups at the provincial, district, sub-district and village levels that have the responsibility for monitoring, supervising and supporting *Posyandu* activities. The team members represent different sectors of local government, including Health, Village Development, Family Planning, PKK (women's welfare organization), Agriculture and Education.

While the creation of the Provincial PST occurred prior to this project, during CS-VII PC1 worked with the Provincial government in training and facilitating the formation of PSTs at the district, sub-district and village levels. By the end of the project, PC1 had held four District PST trainings for 145 participants, 29 Sub-District PST trainings for 455 participants, and 45 Village PST trainings for 1,425 participants in 377 villages. These numbers all exceed the outputs planned for the project.

Midterm evaluation recommendations and subseauent actions taken:

- ***"PCI should discuss with the teams, particularly at the district and sub-district levels, ways for monetarily supporting team function, especially supervisory visits and monthly meetings. These discussions may include examples of how other provinces, districts, and sub-districts support such costs, and may emphasize intersectoral responsibilities. To further support this effort, PCI may have to act as an advocate with the government, and may have to urge the local PST to initiate community fund raising activities."***

  PC1 has held meetings with PSTs at all levels to discuss this and other issues related to team functioning. Three of the four districts have budgeted funds to support PST activities.

  Some teams, at the district level, promoted intersectoral responsibility by utilizing field visits undertaken as part of their regular duties as an opportunity to monitor the sub-district PST at the location of the visit.

  Community fund-raising activities were introduced, as a pilot scheme, in some villages; but this scheme benefitted *kaders* and the *Posyandu*, not the PSTs. No separate community fund-raising efforts were implemented for the PSTs.

- ***'With District PSTs that received allocated funds from the local government, PCI should discuss the possibility and benefits of allocating specific finds for the sub-district teams."***

  In those three districts where funds were allocated, a portion of these funds were also used to support sub-district PST activities.

- *"To reduce costs for the PSTs, PCI should assist in reinforcing a sectoral strategy for supervision utilizing a simple monitoring check list. In supervision, the district PSTs should focus on the regularity of sub-district meetings and supervision to the village level, the availability of local funds, and the use of the monitoring system to regularly identify the three worst villages. The supervision by the sub-district PSTs should focus on Posyandu* implementation."

  PC1 developed a monitoring checklist and distributed it to the provincial, district and sub-district PSTs to facilitate the monitoring process; but the form has generally not been used. The PST monitoring and supervision strategy was clearly planned at all levels, but has not been fully carried out.

- *"Use of the monitoring system should be reinforced. The use of a simplified system, with a minimum of indicators, to determine problematic areas should be implemented. The purpose of team monitoring and the use of the new system could be reviewed during supervisory visits."*

  A new simplified monitoring form (F-l) was developed after the mid-term evaluation and was distributed to the PSTs at all levels. The form has generally not been used, however. Very few supervisory visits have been made, and thus there has been little opportunity to review the new monitoring system.

The roles and objectives of the PSTs at all levels are not clear to the members. During interviews the evaluation team heard repeatedly the perception that the *Posyandu* was the responsibility of the health centers and the health sector generally. This is precisely the perception that the PSTs were formed to counter, as they were intended to mobilize support and resources for the Posyandu from many development sectors--not only health. This finding confirms that of the midterm evaluation; the situation apparently has not changed.

The Posyandu monitoring system does not seem to be functioning adequately at all levels. Supervisory visits are not carried out regularly. The monitoring form developed by the project to measure *Posyandu* functioning is generally not being used. PST members reported that the form is still too complicated, and that it represented an additional burden of paperwork for them.

As a result, PC1 must collect *Posyandu* data directly from the local health centers for project monitoring purposes, because little data is available through the PSTs. This data (called local area monitoring or PWS), covering a variety of indicators of maternal and child health and services, is already collected by health center staff during Posyandu and clinics, but it has remained only with the health centers and the district health offices.

FINAL RECOMMENDATIONS:

- If the form F-l will not be used, then PWS data should be shared with all the PSTs, rather than kept only within the health sector.

- The provincial PST should help the lower level PSTs to clearly define their roles.

Clb. Provincial PST

The Provincial Posyandu Supervisory Team was formed in 1989 by a decree of the Ministry of Home Affairs, which also stipulated the PST's organizational structure and job descriptions. In 1991 PCI provided training to the provincial PST, which included the use of data to identify and address problems with Posyandu implementation and the functioning of PSTs at the lower levels.

The need for refresher training of the Provincial PST was identified by the project and was planned for 1994. However, it was not carried out due to a shortage of funds toward the end of the project.

With facilitation by PCI, the Provincial PST has been able to hold monthly meetings. However, since the team members are senior officials in the ministries, the time they have available to devote to *Posyandu* monitoring is quite limited. According to the PST supervision schedule, the Provincial PST should visit each district PST five times per year. In actuality very few visits were made during the three years of the project. One district PST stated that the Provincial PST visited them only once during this time. One reason for this situation is that some PC1 funds were re-directed from the Provincial PST to support the expansion of TBA training, which required more funds than anticipated.

PCI was advised that the Provincial budget for fiscal year 1994-95 will provide Rp. 29 million (approximately $13,360), through Bangdes, to support the Provincial PST functioning, including meetings, supervisory visits and the radio *Posyandu* quiz program. This funding is intended to continue in subsequent years.

The *Posyandu* monitoring system is still weak, as pointed out in the midterm evaluation. The monitoring form (F-l) is supposed to be completed at the lower levels and sent by the district PST to the Provincial PST quarterly. The Provincial and district PSTs reported, however, that the form is rarely completed and sent to the Province.

To encourage use of the form, the Provincial PST dispatched a letter to the district and sub-district PSTs requesting that they complete the F-l monitoring form regularly and submit it to next higher level, according to the project design. There was no follow-up after this letter, and the effort does not seem to have improved the situation.

Clc. District PSTs

In response to the directive of the Ministry of Home Affairs, a Posyandu Supervisory Team was established in each of the four project districts: Kampar, Indragiri Hulu, Indragiri Hilir and Bengkalis. PCI, in collaboration with the Provincial PST, provided training to these district PST members in four workshops attended by 145 participants. As with the PSTs at other levels, the district PST training focused on the role and responsibilities of the team in monitoring *Posyandu* activity, including the use of the *Posyandu* indicator monitoring form.

The monitoring form initially used was created by PCI and the Provincial PST and distributed to the district and sub-district PSTs; their training was based on this form. As a result of feedback from the PSTs, however, the form was determined to be too complicated, and another, simplified form (F-l) was devised. Data is supposed to be compiled using form F-l and sent from the sub-district to the district monthly, and from the district to the province quarterly.

However, the teams interviewed said they do not use the Posyandu monitoring form. They felt that the form is duplicative and not necessary; and that it is too much work to fill out another form. Some PSTs claimed that the training they had received was not sufficient to enable them to use the form. It was clear to the evaluation team that the PSTs did not understand the purpose or potential usefulness of the form. One district PST stated that they had reported to the Provincial PST only two times in three years, and that reporting from the sub-district to the district PST was equally sporadic.

In effect, the only reporting system being used is that of the MOH, in which reporting of Posyandu health information is done by the local health center staff to the district health office, and from there to the Provincial MOH. Standard MOH reporting forms are used. In some areas, the PST member representing the health sector shares this MOH information with the PST. However, the information is much more complicated than that recorded on form F-l, and it is not in a format which can easily be used as a management tool to monitor *Posyandu* functioning.

The district PST members interviewed during the final evaluation said that their teams meet every one to three months. They were not clear, however, as to the purpose and function of the PSTs. In some areas they had no job descriptions.

Supervision from district to sub-district PSTs is mixed. In some areas it rarely takes place. One sub-district PST stated that the district PST had never visited them. This was explained as being due to very difficult and expensive transportation within the district. Other sub-districts had been visited, but less frequently than planned.

In another district, however, the PST members are able to visit the sub-district PSTs regularly, as part of their normal duties. When possible, supervision visits are made with funds from their respective departments, and are combined with official visits for other purposes. This represtents an efficient way to take advantage of limited resources.

Cld. Sub-district PSTs

As with the district PSTs, a Posyandu Supervisory Team was established in each of the sub-districts in the four project districts. With assistance from PCI, the district PSTs provided the training for the sub-district PST members in 29 workshops attended by 455 participants. The focus of the training was the same as that for PSTs at other levels, except that the sub-district PSTs were instructed in collecting the raw Posyandu data and compiling it on the monitoring form (F-l).

In some sub-districts the PSTs have divided their area into sectors and assigned a member to each sector, as a way to facilitate supervision of the villages and Posyandu. But this plan does not seem to have resulted in an increase in supervisory activity. As reported by the mid-term evaluation, very little supervision is occuring in the sub-districts. PST members said that they see the Posyandu as the responsibility of the health centers, and not theirs. They also do not seem to understand the purpose of the PST, and the role that they could play.

Nor do the sub-district PSTs use the F-l monitoring form or system. As with the district PSTs, they feel it is duplicative, unnecessary and too much additional work They also stated that the district PSTs generally do not request the forms from them, and so they do not feel obligated to submit them.

Instead, Posyandu monitoring is done by the health center staff. They collect the PWS data (on EPI, nutrition, antenatal care and family planning), compile it for all Posyandu in their service area, and submit it to district health office. In some areas they also give a copy of the report to the sub-district PST, but the PST does not use the information.

Cle. Village PSTs

The village-level PSTs are responsible for overseeing the Posyandu in their respective villages. This includes mobilizing mothers to attend, and ensuring that the kaders organize and staff the Posyandu. The village PSTs, however, are not involved in monitoring the Posyandu the way the higher-level PSTs do.

A total of 1,425 village PST members (108% of the target) were given training during 45 training workshops conducted by PC1 and the respective sub-district PSTs. These members (including village heads, village secretaries, Posyandu kaders and heads of the local PKK) represented PSTs in 377 villages throughout the project area. Typically, the head of the PST is a village secretary or Posyandu kader.

Through interviews with members of several village PSTs, the final evaluation team determined that the level of PST functioning varies substantially. In some villages the members stated that the PST meets only every six months and is not involved in mobilizing the community for the Posyandu; they rely entirely on the *kaders* to handle the Posyandu. In other villages, the PST members are more active. They visit homes and religious meetings to encourage mothers to attend; and they come to the Posyandu to assist.

A weakness identified in the mid-term evaluation still holds true: where support is lacking from the sub-district PSTs, the village PSTs are unable to solve Posyandu problems such as irregular attendance by health center staff and the existence of untrained kaders.

C2. TRAINING OF TRADITIONAL BIRTH ATTENDANTS (TBAs)

The training of TBAs has been a central part of the Riau CS-VII project. TBAs provide antenatal and delivery care to mothers in their villages, as well as dispensing health education messages and motivating mothers to take their children under five to the Posyandu.

The project initially trained health center midwives to serve as TBA trainers. A total of 52 midwives received the TOT training in February and April 1992. These midwives then trained selected TBAs in their respective sub-districts, with assistance from PC1 staff. A total of 1,431 TBAs were trained during the CS-VII project (108% of the original plan).

The MOH has embarked on a program to train village-level midwives (*Bidan Desa*) and place them in every village in Indonesia. They would be more extensively trained and able to provide a higher level of care than TBAs, and should thus contribute to a reduction in infant and maternal mortality rates. Midwives have been placed in 424 villages in Riau Province, and the MOH plans to cover all 1,206 villages by 1998.

Midterm evaluation recommendations and subsequent actions taken:

- ***"PCI should discuss options for continued supervision/refresher training of TBAs in areas where monthly arisans*** do not exist. Options may include: having an open session at the Puskesmas on market days, or providing supervision on Posyandu days."

  PC1 encouraged the health centers to hold monthly meetings of TBAs (in conjunction with monthly savings clubs--"*arisans*") during which problems could be addressed and refresher training provided. Of those health centers visited, however, only one was found to be holding these meetings. Several TBAs stated that if a meeting were held, they would attend. One problem identified with health center fuctioning in this regard is the frequent turnover of doctors, which is disruptive to ongoing programs.

  As an alternative to meetings at the health center, in those villages with a resident midwife, the project has encouraged these midwives to meet regularly with TBAs (many mothers cannot afford the higher fees charged by the village midwives). TBAs interviewed for the final evaluation report good relations with village midwives, who sometimes help them to improve their knowledge.

- ***"A change in the length of TBA training and a plan to carefully monitor this change to ensure that adequate time is available to appropriately cover information with illiterate TBAs, previously untrained TBAs, or TBAs who do not speak Bahasa Indonesia should be promoted."***

  This recommendation was made as a result of a perception that TBA retention of specific knowledge on issues covered during training, especially those outside of birthing practices, was weak Subsequently, project management concluded that TBAs could not easily master these issues. As a result the length of TBA training was reduced from six days to four. Sections of the curriculum addressing immunization, CDD and other interventions are no longer explained in-depth, but are only generally mentioned. TBAs are simply taught to send mothers to the Posyandu for problems or services other than maternity care.

  The final evaluation team found that some TBAs have retained a great deal of information. During interviews they were able to answer specific questions about safe birthing procedures, high-risk signs, proper cord care and sterilization of scissors, as well as immunization. In other areas, however, TBAs' knowledge was poor, especially regarding immunization. It should be noted that the final evaluation did not include a random survey of a sample of TBAs, but merely informal interviews with those TBAs coming to the health center on the day of the team's visit. Ideally, an assessment of TBA's retention of knowledge would utilize pre-test and post-test surveys, with the post-test coming after the TBAs had been functioning for many months.

- ***"Pre- and post-tests and results from baseline and final TBA surveys should be used to review and refine, if necessary, the content, style and riming of TBA training."***

  The project conducted a "baseline" survey of 206 TBAs in February 1993. The data from this survey has not yet been analyzed; but project management used the insights gained from the baseline survey exercise to revise the TBA curriculum, as described above.

- ***"To sustain motivation among TBAs, PCI should urge the District MOH to introduce a social reward system for TBAs in an effort to compensate for the financial losses the TBAs are experiencing due to the success of family planning."***

  The final evaluation team concluded, based on interviews with TBAs, that this issue is not a real concern of most TBAs. The team was impressed with the attitude of many TBAs who simply wanted to be of service to the women in their communities, and were less concerned about the financial rewards of their work. TBAs are well-respected in their communities, and seem to enjoy even more prestige after they receive training.

- ***"PCI should urge the District MOH to reinforce the importance of health center staff following up on TBA birth reports."***

  PC1 has discussed this issue with the district health offices in the project area. There is no quantitative evidence to document a change in the frequency of follow-ups to births.

The final evaluation team found that the activity level of the TBAs varies a great deal from one to another. The TBAs interviewed reported that they had assisted in the deliveries of from three to twenty babies during the period of January to June 1994. They said that they were active in promoting the Posyandu among mothers, and in encouraging the use of family planning. They also teach mothers about ORT, nutrition, exclusive breastfeeding, and proper weaning practices. (These fmdings were confirmed by interviews with groups of mothers in the villages visited.)

The placing of resident midwives (*Bidan Desa*) in some villages appears to have had an effect on the demand for TBA services. Health center staff in one area said there is still strong demand for TBA services, but as midwives are trained and posted to villages, more and more mothers choose to go to them for delivery, because they are perceived to be better qualified. Some TBAs confirmed this impression. They added, however, that many mothers continue to patronize them because their fees are much lower than those charged by the midwives. Indeed, some TBAs do not charge a fee at all if a mother cannot afford to pay.

The reporting of TBA-assisted births has been sporadic. In some areas TBAs complete the birth reporting forms but do not take them to the health center, especially if no monthly meetings are held. Many TBAs keep the forms unless they are visited by a midwife or health center staff member to collect them; and some TBAs do not go to the Posyandu. The result is that, in some villages, reporting is rarely done.

FINAL RECOMMENDATIONS:

- Yayasan Utama should analyze the results of the TBA survey. The results could be useful for its future activities with TBAs.

C3. TRAINING OF VILLAGE HEALTH WORKERS ***(Posyandu kaders)***

Posyandu *kaders* are village residents who volunteer to help with the organization and running of the Posyandu sessions. This includes mobilizing the community to support and attend the *Posyandu*, and

staffing the tables where the health services are provided. They are responsible for registering mothers and children, weighing babies and providing nutrition education, as well as assisting the health center nurses in delivering other services. Many ***kaders*** are members of the local women's social welfare club (PKK).

A total of 700 kaders were trained during the project, by PC1 and staff of the local health centers, with planning and coordination assistance from the PSTs.

Many of the currently active ***kaders*** have not received training, and a number of those trained have discontinued their activities. *kaders* interviewed during the final evaluation stated that there is substantial drop-out, due to loss of interest over time. On the other hand, many kaders were quite dedicated, and had worked at the *Posyandu* for several years. Those inteniewed were knowledgeable about the health services, including immunization, growth monitoring and nutrition.

In two sub-districts, the project introduced an income-generating scheme involving loans to the kaders (See section El. for a detailed description.) Anecdotal reports indicated that this scheme helped to improve the morale of the participating ***kaders.*** However, no formal analysis was done to assess the impact on kader functioning or attrition. Also, in some villages kaders are given uniforms by the village head, as a form of incentive for their work.

C4. INCREASING COMMUNITY PARTICIPATION (Social Marketing)

C4a. School *Posyandu* (PPAS) Program

The PPAS program is an innovative, school-based Posyandu education scheme that has been implemented in one sub-district in each of the four project districts. A total of 26 schools, including 56 teachers and 2,222 students, have been involved in the program. Primary and secondary school students are taught about primary health care and the Posyandu and are responsible for "recruiting" mothers in their villages and encouraging them to bring their babies to Posyandu. Teachers are initially trained by PC1 in maternal and child health topics and the PPAS curriculum, and are provided with an instruction manual. They then lead their students through the curriculum during the course of the school term, using lecture, discussion, role-plays and a field trip to a local Posyandu.

Midterm evaluation recommendations and subsequent actions taken:

a "***PCI should discuss with the Ministry of Education/Schools the possibility of expanding the curriculums to better enable the Posyandu*** School Program to be implemented effectively."

This issue was discussed with the Ministry of Education, and it was agreed to include the PPAS in the "sports and health" curriculum where it would receive more time. During the final evaluation, teachers reported devoting from one to five hours per week to the PPAS curriculum.

- ***"PCI should consider expanding the School Posyandu*** Program after appropriate **review** with the Schools/Ministry of Education and ***the Posyandu*** Supervisory Teams."

By the end of 1994 the Ministry of Education plans to expand the School Posyandu Program from 25 to 125 schools, pending availability of funds.

- ***"PCI should discuss possibilities for transferring supervisory responsibilities for the School Posyandu*** Program with the Ministry of Education."

  Discussions were held regarding this issue. The Ministry of Education is planning to take over supervision of all PPAS schools--those presently active and those to be added--within the next year. The ministry stated that they have funds available to support this supervision.

- ***"PCI should review possibilities for providing reference materials for teachers and students in the School Posyandu*** Program."

  This recommendation was made as a result of frustration expressed by some teachers at not having access to adequate reference materials to supplement the PPAS curriculum, including educational posters and a more advanced teacher's manual. However, the project was not able to provide these materials within its budget and time frame.

- ***"Within the School Posyandu*** Program, **PCI** should consider initiating student discussion groups in the Junior High Schools and in the Elementary Schools using the existing active group study method (CBSA)."

  This recommendation was not implemented by the project. It was not considered to be a priority.

- ***"PCI should discuss with the trained teachers the possibility of utilizing an active simulation educational method for the School Posyandu*** Program."

  This recommendation was not implemented for the same reason: it was not considered a priority, given time and budgetary constraints.

Data were collected by PC1 measuring Posyandu attendance in the PPAS program sub-districts during the period of May 1992 to January 1993. The results show that average Posyandu attendance in these areas rose by **7.9%**, from 30.4% to 38.3%. We would have expected a larger increase in Posyandu attendance as a result of the PPAS program, based on **PCI's** experience in Maluku Province with a similar program which demonstrated an attendance increase from 33% to 77%. However, there are many factors which could have affected Posyandu attendance in these areas of Riau, and it is not possible to draw conclusions about the success of the PPAS program based on these data alone.

Other information was obtained from PPAS teachers interviewed during the final evaluation. Most teachers reported that their students' knowledge about health issues increased substantially as a result of the PPAS. This knowledge was measured during end-of-term tests which included questions about **PPAS** topics. No written documentation of the results was available.

As one of their assignments, students in the PPAS program are taken to a Posyandu to observe the session and interview the Posyandu ***kaders***. All students visit at least one Posyandu. This visit

provides them with first-hand experience of the function and value of the Posyandu. The evaluation team felt that this is an excellent way to introduce young people to the local health service delivery system, and to inform them about what services are available.

Another innovation is the use of a classroom chart on which students record the names of the mothers they "register", and track their attendance at the Posyandu. This provides a tool for the students to use in motivating mothers to attend the Posyandu. However the use of this chart is not universal. It is used in some PPAS schools but not in others.

FINAL RECOMMENDATIONS:

- The Ministry of Education should introduce the mother registration chart in all PPAS schools, to encourage Posyandu attendance by mothers and to facilitate measuring students' activity.

C4b. Radio ***Posyandu*** Quiz

The provincial radio station, Radio of the Republic of Indonesia (RIU), has assisted the Child Survival effort in Riau by broadcasting a series of Posyandu quiz shows to its listening audience. Posyandu quiz episodes were designed by PC1 and broadcast by RRI every two weeks. During the life of the project, 27 Posyandu radio quiz shows (112% of the target) were produced and broadcast throughout the province.

The radio quiz shows consist of two parts: First, three teams of local health volunteers compete to correctly answer a series of questions about community-based maternal and child health. The teams are awarded prizes based on the scores they achieve. In the second part, questions are read directly to the radio audience, and they are encouraged to call or mail in their responses.

Midterm evaluation recommendations and subsequent actions taken:

- ***"PCI should try to contact and discuss with local radio stations the possibility of their being involved in the social marketing radio program."***

  This recommendation was made because the RRI signal--including the social marketing programs--could not be received in all areas of the province. Since then, RRI has boosted the strength of its signal, and it's broadcast can now be heard throughout the province. This development eliminates the need to utilize local radio stations.

- ***"PCI should discuss with the Pekanbaru Radio Station the possibility of substituting popular folk songs (Dangdut) for the more modem music currently used in the &lo-based social marketing program."***

  These discussions have been held, and RRI is now using dangdut and other folk songs in the social marketing program. This music is considered to be more acceptable to rural residents.

The final evaluation team did not have the opportunity to observe a radio quiz show in progress. Instead, we were limited to discussing the topic with PC1 and MOH staff, who felt the program was

very successful. The team agreed that the concept of the radio quiz was solid, and that it was an efficient method of disseminating health education messages to a wide audience.

Audience reaction to the quiz shows appears positive, with an average of 200-400 responses received for each episode. It was not possible, however, to demonstrate an increase in popular knowledge about the health messages. This is not surprising, as this type of data would have to be collected by large--and expensive--population-based surveys. The project's final survey did not include this topic.

Anecdotal reports, from staff and aquaintances, indicate that the radio quizes are indeed popular. And commercial sponsors (including P.T. Gizindo Prima Nusantara, P.T. Pangan Inti Kusuma and P.T. Indomie) lent their support by donating money for prizes to be awarded to the quiz show contestants.

C4c. Newspaper Crossword Puzzles, Articles and Advertisements

Two provincial newspapers, The Riau Post and Genta, have supported the social marketing program by regularly publishing crossword puzzles, articles and advertisements focusing on a variety of health themes related to Child Survival. This publicity, provided at no cost to the project, has also assisted in the promotion of the Posyandu.

During the life of the project, a total of 38 crossword puzzles (105% of the target), 25 articles (138% of the target) and 126 social service advertisements (350% of the target) were published by these two newspapers.

In addition, the project has produced 3,000 leaflets and 200 posters promoting health education messages and distributed them through religious leaders and their congregations.

Midterm evaluation recommendations and subsequent actions taken:

- ***"Questions aimed at assessing the overall impact of the media based social marketing programs should be included in the final population-based survey."***

  The mid-term evaluation team concluded that it was difficult to assess the impact of the social marketing program without a population-based survey. However, these questions were not included in final survey due to an oversight.

- ***"PCI should discuss with the Riau Post the possibility of including the social marketing programs in the village-based weekly newspaper. The distribution of the programs through such a mechanism would be useful in all the districts, but particularly in Indragiri Hilir."***

  The project did not discuss this recommendation with the Riau Post, because they felt it would be too difficult economically for the newspaper to carry it out.

- ***"PCI should focus the media based program on more practical issues needed by kaders*** and mothers to maintain family health."

  To address this issue, PC1 began consulting with the Ministry of Health in the design of health messages used in the media-based program.

C5. LOCAL NGO DEVELOPMENT

An important part of the initial plan for the Riau CS-VII project was to establish and support a local NGO capable of conducting maternal and child health activities on its own and in collaboration with the MOH. In this way PC1 would make a further contribution toward the sustainability of health services in Riau. This strategy had been used in Southeast Sulawesi, where PC1 helped establish a successful NGO, Yayasan SINTESA. In Riau, a core of PC1 staff have formed Yayasan Utama, officially registered the organization, and identified a board of directors. Already Utama has implemented a number of projects, with support from PCI, as listed below. During final evaluation interviews with MOH staff, it was clear that they respected Utama's abilities, and intended to continue working with them in the future.

Activities Utama has undertaken to date:

IMR/MMR survey. Under a grant from the Riau MOH, Utama conducted the first province-wide IMR/MMR survey ever attempted in Riau. Utama implemented the survey with its own staff, and contracted with some PC1 staff to assist them. An unanticipated benefit of this activity was that Utama/PCI staff were able to monitor certain CS-VII project sites during field visits for the survey.

TBA and kader training. The National Family Planning Board (BKKBN) contracted with Utama to train Posyandu kaders and TBAs, using the "Learning to Listen to Mothers" curriculum developed by the Academy for Educational Development. A total of 28 kaders and 28 TBAs were trained from December 1993 to February 1994.

HIV/AIDS TOT. A group of companies in Riau Province (including Caltex, Indah Kiat Pulp and Paper Company, and Indrayani Hotel) contracted with Utama to conduct a training of trainers (TOT) workshop, focusing on HIV/AIDS education, for 30 members of their staffs.

HIV/AIDS TOT. Utama also conducted an HIV/AIDS training of trainers workshop for SO members of FKPPI, a youth organization for children of the military.

Midterm evaluation recommendations and subsequent actions taken:

- ***"For improved organizational development, PCI should provide direct supervision and guidance for Utama and Kosgoro for a substantial amount of time after program implementation, approximately one year."***

  During the course of the CS-VII project, PC1 helped develop the skills of the staff of Yayasan Utama, focusing particularly on financial and administrative management. In addition, since the mid-term evaluation, Utama staff have benefitted from on-the-job training and practical experience gained through the management of several contract activities, as outlined above. And some Utama staff have made observation visits to the PCI/Maluku Child Survival project, and to other NGOs in Sumatra and Sulawesi, to learn about their community-based health programs and management methods.

  After the CS-VII project period, Utama will implement, under a sub-contract from PCI, a

community-based HIV/AIDS education project in Riau. As part of this project, which will last until May 1995, PCI/Jakarta will provide periodic technical assistance to Utama covering program development, management and HIV/AIDS technical components.

- ***"A strategy to minimize competition for staff time between PCI's and Utama's portions of programs should be developed."***

The problem of competition for staff time between Utama and PC1 continued to be an issue through the end of the project period, although it never grew to the point of jeopardizing the implementation of program activities. The staff learned to be flexible in allocating their time during especially busy periods. At one point, Utama had planned to accept an AIDAB contract to conduct an evaluation of another NGO; but the PC1 Country Director did not allow Utama/PCI staff to accept the contract, for fear that they would be drawn away from CS-VII project activities at a very busy time for the project.

- ***"PCI should work with Utama in defining a formal relationship describing the details of future support and fund-raising, including a clear discussion of responsibility for developing and submitting proposals to funding agencies."***

PC1 has assisted Utama in its fund-raising efforts by making introductions to potential donors in Jakarta (such as foreign embassies and international projects); by critiquing proposals; and by including Utama staff in a PCI-sponsored workshop on writing HIV/AIDS proposals. In addition, Utama submitted a successful proposal to PCI's EPOCH project for sub-grant funding to implement HIV/AIDS activities in Riau.

- ***"PCI should assist Utama in conducting a local consumer's demand analysis. Organizations / groups to be included in this analysis should include but not be limited to the following: government institutions, private companies, and the general community."***

PC1 has not yet assisted Utama in developing this consumer demand analysis, although PC1 has discussed with the Riau Provincial MOH the experience accumulated by Utama staff, and encouraged the MOH to take advantage of Utama's services whenever possible.

- ***"PCI should assist Utama in identifying and lobbying for local professionals to be listed in a consultants pool. These consultants could then be utilized for future Utama projects."***

A "local consultants pool" has been compiled, currently consisting of 13 persons experienced in various aspects of community health. Several consultants have been contracted, including Dr. Dede Utomo, an AIDS expert, and Dr. Dewa Nyoman Wirawan, from Udayana University in Bali, who provided technical assistance for the provincial IMR/MMR survey.

- ***"PCI, Utama and Kosgoro should discuss the possibility of Kosgoro acting as the partner of Utama in pursuing future activities and self-reliance."***

Yayasan Kosgoro is based in Jakarta, and maintains a branch office in Pekanbaru, Riau. For the Riau CS-VII project, Kosgoro assisted with TBA and PST training in the district of Indragiri Hulu, ending in September 1993. At that point PC1 decided to discontinue working with Kosgoro in order to focus more on the development of Yayasan Utama.

Continuing support needed by Yavasan Utama:

During the final evaluation, Utama staff described the current status of the NGO and what they perceive to be their needs for continuing support in the short term. The evaluation team agreed that these items are appropriate.

- Continued assistance in identifying and contacting international NGOs and PVOs which could potentially provide funding.

- Further training for Utama staff in NGO management, HIV/AIDS interventions and maternal and child health.

- On-going financial support for Utama staff members' salaries for up to one year (September 1994 - August 1995).

- Approval of Riau Provincial MOH to allow Utama to continue to occupy the office space used by PC1 during the CS-VII project.

PCI/Indonesia, through its country office in Jakarta, intends to continue actively advocating for Utama and informing them of possible funding opportunities, through local and international sources. Part of the responsibility of the PC1 Country Director is to cultivate potential funding sources, for PC1 projects, and for PCI's partner NGOs. In addition, PCI's Resource Development Department in San Diego will keep an eye open for donors who may be appropriate for Utama.

As mentioned above, the new HIV/AIDS project Utama is implementing in Riau will include the provision of technical assistance from PCI's EPOCH project. Specifically, EPOCH's consultant advisors will visit Utama to work with their staff in the areas of NGO management and HIV/AIDS program implementation, including counselling, IEC, STD management and social science research methods.

The issue of financial support for Utama staff members' salaries has not been resolved, although the sub-grant for HIV/AIDS activities includes some funding for salaries.

The Provincial MOH, which owns the PCI/Riau office building, has agreed to allow Utama to continue to occupy the office space for a period of one year. During that time Utama will make arrangements for more permanent facilities.

FINAL RECOMMENDATIONS:

- PC1 should assist Utama to develop expertise in health information systems (HIS), for more effective collection and use of program data. This may involve adding an HIS expert to the staff, or training existing staff in HIS.

II. PROJECT SUSTAINABILITY

A. Community Participation

A1. COMMUNITY MEMBERS AND LEADERS INTERVIEWED

Tandun Sub-district (Suka Damai and Uiung Batu villages):
T. Fauzan, Head of sub-district
Amiruddin Durani, Secretary/Vice Head of sub-district
Group of TBAs
Group of ***Posyandu kaders***
Group of elementary and secondary school teachers
Group of elementary school students
Group of mothers of children under five

Kunto Darusalam Sub-district (Kota Lama and Paearan Tapah villages):
Group of TBAs
Group of ***Posyandu kaders***

Enok Sub-district (Enok and Simpang Tiga villages):
Dahlius, Head of Sub-District Education Departement
Rafai, Elementary School Supervisor
Sudirman, Elementary School Supervisor For Sport & Health Education
Nasrun, Elementary School Master
Group of elementary school teachers
Group of elementary school students
Dr. Amruddin, Head of health center
Group of TBAs
Group of ***Posyandu kaders***
Group of mothers delivered by TBAs

Batang Tuaka Sub-district (Sungai Piring and Sungai Luar villages):
Group of TBAs
Group of mothers delivered by TBAs

A2. Two interventions were most commonly mentioned by the community members and leaders intetviewed. They are child immunization and TBA services. Especially where there is no village midwife or the midwife's fee is too expensive, the TBAs are appreciated and patronized. And immunizations generally are seen as "powerful medicine." When asked, many respondents said they did not think child weighing/growth monitoring or health education were particularly valuable services.

A3. While the entire project was designed to build the capacity for local health service delivery, three activities directly targetted community members. First, the improvement of Posyandu implementation was a central focus of the project. This included the training of Posyandu kaders to organize and manage the sessions; and the training of PSTs at several administrative levels to monitor and address problems and deficiencies with the Posyandu.

Secondly, the training of TBAs was also a core of the project. The TBAs, who are resident in the community and respected and patronized by community members, were given training in improved birthing techniques and referral of high-risk pregnancies, as well as methods for educating the community about child survival interventions. (Section C2 provides more detail on TBA training.)

Finally, the health education component, especially the school *Posyandu* program, was designed to efficiently influence local health behavior. The school Posyandu program trained local elementary school teachers to educate their students about important health issues, and to pass this information onto their mothers. Once trained, these teachers should continue this instruction during each school term. (Section C4a provides more detail on the school Posyandu program.)

A4. The CS-VII project was designed by PCI and provincial Ministry of Health staff, based on the design of the previous CS-IV project in Riau, and the experience gained implementing it. The community members were not directly involved in the design.

The implementation of project activities depended heavily on community members who were identified and trained. As described in section C2, a total of 1,431 TBAs were trained during the project, and have been providing antenatal, birthing and referral services to village mothers. Village-level PSTs (including village leaders, Posyandu kuders and others) were trained to promote and oversee the *Posyandu* in their respective villages, as described in section Cle. Finally, a total of 700 Posyandu kaders received training during the project, although there has been some attrition (see section C3). It is the kaders' responsibility to promote and organize the monthly Posyandu sessions, and to assist with registration, weighing of babies and health education. They are all residents of the village in which they serve.

Many community members were interviewed as part of the final evaluation exercise, as listed in section Al above, as well as during the midterm evaluation. They were not involved in designing or carrying out the evaluation itself, but the assistants to some village heads served as local guides during both the baseline and final project surveys.

A5. In the context of this Child Survival project, health committees consisted of the Posyandu Supersivion Teams (PSTs) which were established at the provincial, district, sub-district and village levels. (Section Cl describes the PSTs in detail.) There is one provicial team, four district teams, 29 sub-district teams, and 377 village teams.

The level of activity of these teams varies by location; however, most teams have not been active and have met less frequently than originally anticipated. The Provincial PST meets monthly, but most of the teams at the district, sub-district and village levels stated that they are not able to meet regularly.

Members of the provincial, district and sub-district PSTs are drawn from various development sectors of the government, and as such are representative of those sectors which have an interest in rural development and health. They are not, strictly speaking, representative of the communities in which project activities are being implemented. The village teams, however, are more representative of the local communities, and include members drawn from the women's welfare organization (PIE), *Posyandu* kaders, TBAs and the village heads.

A6. There has been little activity by PSTs, and thus the number of issues they have addressed is limited, as described in section Cl. Three of the four district PSTs have lobbied for, and received, funding from the district government budget to support their function.

The provincial PST has been involved in supervising the monthly *Posyandu* radio quiz program, which is broadcast by the Radio of the Republic of Indonesia (RRI). They have also provided financial support for the development of the radio episodes.

Some village PSTs have been actively addressing the issue of Posyandu attendance, and have helped to mobilize members of their communities to attend the *Posyandu* more regularly.

A7. According to the project design, the PSTs were assigned the role of monitoring the implementation of Posyundu in their respective areas. A monitoring form (F-l) was developed for this purpose, which assigns a score for each of five indicators, including attendance at Posyundu and coverage of eligible children or women with DPT-1, Polio-4, pre-natal examinations and family planning services.

Using the scores reported on the forms, each sub-district PST was responsible for monitoring the Posyandu occuring within its sub-district. The district PSTs in turn were to monitor the average Posyandu scores for each sub-district within their respective districts; and the Provincial PST was to monitor the activity of each of the four project districts. Areas found to be performing poorly should be given special attention, including a visit by the responsible PST and possible mobilization of additional resources to address the problems identified with *Posyandu* functioning.

In reality, however, few PSTs have performed the roles outlined for them in the project design. As mentioned above, most PSTs have met only infrequently, and they have rarely made monitoring visits to the lower level PSTs. (See section Cl for a discussion of the PSTs at each level.)

A8. The community resources contributed to the project have predominantly taken the form of individual time and effort. For example, trained TBAs are village residents who provide antenatal, delivery and referral services for free or at low cost to village mothers. Members of village PSTs and the women's welfare organization (PKK) volunteer to promote and oversee the Posyundu sessions. And Posyundu *kaders* volunteer their time, in some cases for several years, for Posyandu promotion and health education delivery. In addition, some village have rewarded the Posyandu *kaders* by giving them attractive uniforms.

A9. The principal resource expected to be contributed by the PSTs is the time and effort of their members. As detailed in section Cl, the stated reasons why few PSTs perform the responsibilities outlined for them are that they do not clearly understand their roles vis-a-vis the *Posyandu* or the possible impact they could have on Posyandu quality and services; and that they do not use the Posyandu monitoring form, because they see it as duplicative and an unnecessary addition to their paperwork

Most PSTs also claimed they do not have adequate funds to perform their duties, especially to make monitoring visits to lower-level PSTs. This is particularly true at the subdistrict level. The PSTs do not have their own funding base, but rely on the respective government level to provide them with operating funds. The administrations of three of the four districts in the project area have budgeted

funds for PST functioning.

Provincial government funds have been budgeted to support the activities of the Provincial PST, including meetings, supervisory visits and the radio *Posyandu* quiz program. The principal constraint for the Provincial PST is time, as its members are senior government officials who are very busy with their duties.

B. Ability and Willingness of Counterpart Institutions to Sustain Activities

B1. MEMBERS OF COUNTERPART INSTITUTIONS INTERVIEWED

Provincial Ministry of Health:
Dr. Salohot, Head of MOH for Riau Province
Dr. Yusman, Head of Communicable Disease Control; PST member

Provincial PST:
Dr. Yusman, AR
Drs. Asmar Saleh
Drs. Zaimi, MZ
Drs. Tatang T. Mukti, SKM
Dra. Yulizar Maralis
Drs. Anis Daulay
Drs. H. Masrul Ismed
H. Harun Badillah, Bsc
Dra. Mislama
Arisun Agus

Kampar District PST:
Dr. Thamrin Manap, Head of MOH, Kampar district
Bachtiar I. Kasuma, Head Community Health Services Section
Surip, Head of Community Health Education Section
Dwi Astuti, staff of BKKBN
Nursal Y, Head of MOH Administration Section
HJ. Elly Darni, PKK representative
Dedy Rochyani, Head of Nutrition Sub-section
Dr. Sunirwan Ismail, Head of Communicable Disease Section
Drs. Arman M. Nur, Head of Community Training and Education Section, *BangDes*

Tandun Sub-district (Suka Damai and Ujung Batu villages):
Dr. Haery Purnomo, head of health center, Tandun II; PST member
Muhammad Taufik, health center staff; PST member
Sunarti, health center staff; PST member
Dr. Nyoman Swarta, head of health center, Tandun I; PST member
Syaiful, health center staff; PST member
Other PST members

Kunto Darusalam Sub-district (Kota Lama and Pagaran Tapah villages):
Members of sub-district PST

Indragiri Hilir District PST:
M. Silitonga, Assistant to PST Head
Amran, PST Secretary
Erni Ismail, member
Drs. M. Amin Ramli, member
Hadran, member
Momot Prabowo, member
Hudari, member
Deliamah Y., member
Ismail, member
Surahbil, member
Sugeng, member
Syahril, member

Enok Sub-district PST:
M. Thaher, Sub-district Area Secretary
Mukti Ali, member
Masri Ag., member
Said Ali, member
Junaidi, member
Sudirman, member
Dr. Amruddin, Head of health center

Batang Tuaka Sub-district PST:
Drs. Junaidi, Head of Sub-district
Ny. Junaidi, Head of PKK
Darmansyah, PST Secretary
Rush Murad, health center staff
Edi, health center staff
R. Zailani, Sub-district administrative officer
Marpoyanto, Field officer for Family Planning Bureau
Darussalam, Sub-district administrative officer
Sukardi, Head officer of Agriculture Advisory
Siti Raudah, Information specialist
Sy. Khairani, Staff of Sub-district Religious Affairs Bureau
S. Ismail Ba, Head of Sub-district Religious Affairs Bureau
Abdul Wahab K., village head

B2. The CS-VII project has been considered a partnership, and was implemented jointly by PCI and the Ministry of Health. The Ministry of Health includes the Provincial MOH, district health offices and local health centers (*Puskesmas*). PCI's role was to facilitate project activities through training, technical assistance, financial support, as well as providing the initiative and momentum to make things happen.

The Ministry of Education, including local school teachers and headmasters, collaborated with PC1 in implementing the School *Posyandu* Program (see section IC4a).

The Provincial PST also served as a counterpart institution to PCI, and has been responsible for supervising the functioning of the district, sub-district and village PSTs, as described in section IC1b.

In addition, the Village Development Office (Bangdes) at the provincial, district and sub-district levels, collaborated with the project, and assigned its local representatives to serve on the PSTs.

Finally, several other organizations provided assistance to the project. Two provincial newspapers, The Riau Post and Genta, supported the social marketing program by publishing crossword puzzles, articles and advertisements focusing on health themes related to Child Survival (see section IC4c). And the radio *Posyandu* quiz shows were broadcast by the Radio of the Rebublic of Indonesia (RRI), and quiz prizes were donated by two companies: P.T. Gizindo Prima Nusantara and P.T. Pangan Inti Kusuma (see section IC4b).

B3. The counterparts mentioned above are expected to continue their support of project activities. This includes the MOH at all levels; the Ministry of Education, teachers and headmasters; the Village Development Office at the provincial, district and sub-district levels; and supporters of the social marketing programs: the Riau Post, Genta, RRI, P.T. Gizindo Prima Nusantara and P.T. Pangan Inti Kusuma. The PSTs, however, do not appear likely to be able to play an effective role in supporting local health services in the future (see section IC1).

B4. During interviews for the fmal evaluation, counterpart members most often mentioned the following project activities as being the most effective:

- TBA and kader training. The TBAs are widely respected and patronized, and the TBA training curriculum has been adopted by the local MOH for a separate training program. Posyandu kaders were also mentioned as effective, but they were considered less sustainable due to a higher drop-out rate.

- School Posvandu Program. The PPAS program was seen as effective by MOH staff, as well as teachers and headmasters. The provincial PST has made a commitment to continue funding the PPAS in 100 schools during 1994-95.

- Radio Posvundu quiz. The quiz show is now broadcast throughout the province, and there appears to be a wide audience, judging from write-in responses to the show's questions, which average 200-400 monthly.

B5. Skills-building was an important part of the CS-VII project. PC1 trained 52 local health center (*Puskesmas*) midwives to serve as trainers of TBAs, and subsequently assisted these midwives in carrying out TBA training sessions, in which 1,431 TBAs were trained. Through this activity, the midwives aquired valuable experience, including adult education training techniques and supervision skills.

Training for trainers was also provided to district and sub-district PST members, to strengthen their ability to train lower-level PST members and Posyundu kaders within their respective areas. As with the TBA training, PC1 subsequently collaborated with the PST members in conducting the training sessions.

Finally, the staff of Yayasan Utama received training in administrative and financial management, to build the skills they will need to continue developing and managing community health programs on their own. Utama will also be available to assist MOH projects as needed (see section IC5).

B6. The Provincial PST, through the MOH and other development sectors represented on the team, has a 1994-95 budget of Rp 20 million ($9,368) to support its monitoring and coordination activities. It also has a budget of Rp 10,000,000 (US$ 4,684) to implement the School Posyandu Program in 100 schools for 1994-95. The organizations listed in section B3 have also pledged to continue providing the resources needed to support the social marketing program.

As for human resources, the constraints mentioned above are obstacles to sustainability. The PST members at the district and sub-district levels have not been active and do not understand the role they should play regarding Posyundu monitoring; and the Provincial PST members have limited time available in their busy schedules.

B7. See section B4.

B8. Since the beginning of the project, PC1 has worked closely with key local institutions to prepare them to assume responsibility for managing Child Survival activities. The project was designed as a partnership between PC1 and these counterparts, to improve the likelihood of sustainability.

For example, the project trained nurse-midwives and doctors from the local health centers (*Puskesmas*) in TBA training and supervision techniques, imparting to them the skills needed to continue training new TBAs and to supervise existing ones.

The project intended to hand over responsibility for kader training and supervision, and Posyundu monitoring and problem-solving to the PSTs. However, as described above, most PSTs are not actively performing these roles. Currently, the Provincial PST and the MOH are considering what steps to take to either strengthen the PST system or find another strategy for Posyundu support.

During the project, the village PSTs and *Posyandu kaders* were trained and given responsibility for the organization and management of *Posyandu* sessions. As we have seen above, this arragement is working better in some villages than in others.

The management of the School Posyundu Program has been handed over to the Ministry of Education. Primary and secondary school teachers and headmasters have been trained to present the PPAS curriculum in the schools, and can continue to teach their students each term with almost no recurrent costs.

B9. Several counterpart institutions made financial or cash-equivalent commitments in support of the project. The Radio of the Republic of Indonesia (RRI) supported the health education Radio quizes, by providing free airtime twice monthly, valued at Rp 112,500 (US$ 53) for each program. Cash prizes for the quiz shows, totaling Rp 400,000 (US$ 187) for each episode, were donated by P.T. Gizindo Prima Nusantara, P.T. Pangan Inti Kusuma and P.T. Indomie. The Provincial government also pledged Rp 19,272,000 to sustain the radio quiz program. Together, these funds are sufficient to continue the radio quiz series.

Some of the same local businesses, including P.T. Gizindo Prima Nusantara and P.T. Indomie, as well as P.T. Caltex, also gave funds to purchase prizes for children who scored the highest in the School Posyundu Program.

The The Riau Post and Genta newspapers committed to supporting the social marketing program by publishing health education crossword puzzles twice monthly, as well as occasional articles and advertisements, at no cost to the project. The print space for the crossword puzzles was valued at Rp 1,000,000 (US$ 468) for each puzzle. The newspapers also provided prizes valued at Rp 100,000 (US$ 47) for the contest winners. After the CS-VII project, Yayasan Utama will continue to design the puzzles, and the The Riau Post and Genta will continue to print them.

B10. The final evaluation team did not have the opportunity to interview representatives of RRI, the The Riau Post and Genta newspapers, or the various commercial sponsors. But PCI/Riau staff reported that these counterparts and sponsors were satisfied with the nature and quality of the social marketing programs, and thus were willing to keep their financial commitments. The sponsors also received valuable publicity by being associated with the programs. Project staff said there were no financial commitments which were made but not kept.

B11. Staff of the district health offices assisted in conducting the project's final survey. And the National Ministry of Health, and an NGO based in Sulawesi, Indonesia (Yayasan SINTESA) sent a member of their staffs to serve on the final evaluation team. For the mid-term evaluation, the National MOH and a Jakarta-based NGO (Yayasan Kusuma Buana) sent staff members to serve on the team. Counterparts at the Provincial, district and sub-district levels assisted with arrangements for the evaluations, but did not have a role in the design or analysis.

C. Attempts to Increase Efficiency

C1. PCI made several arrangements which helped to reduce costs for the project:

- Local companies and media organizations were recruited to support the social marketing program, and thus reduce the investment PCI needed to make in these activities.

- Working closely with Ministry of Health personnel, PCI implemented a training of trainers methodology utilizing existing local health staff and PST members to train TBAs and *Posyandu kaders*. This method was more cost-effective, as well as sustainable, than having PCI staff conduct all the training.

- All PCI/Riau staff members are Indonesian citizens, and thus cost the project less money than posting expensive expatriates.

- And the project area was reduced from seven districts to four to improve efficiency and cut costs associated with working in remote areas of the province. PCI's Child Survival IV project in Riau had also included the remote district of Riau Kepulauan and the municipality of Pekanbaru.

C2. The above arrangements were successful for several reasons:

- Local businesses and media houses recognized the value of PCI's health education programs, and PCI's strong reputation in Riau Province, and were motivated to lend their support.

- PCI enjoys a close working relationship with the Ministry of Health at all levels, which has made it possible to coordinate with them on many activities, and to share costs.

- Fortunately, Indonesia possesses a wealth of talented and experienced health and development professionals, and PC1 was able to select highly qualified local staff for the Riau Child Survival project.

c3. It is important for the PVO to collaborate to the greatest extent possible with local institutions such as the Ministry of Health, NGOs and private enterprises. This strategy not only increases efficiency but also improves project sustainability.

D. Cost Recover-v Attempts

D1. Cost recovery was not included as part of the project design. However, a small pilot scheme was introduced in two villages in Tandun sub-district. In this scheme, village drug post kaders used a revolving drug fund (RDF) to resupply their stock of drugs. Two drug posts were involved, staffed by two kaders each. These four kaders were trained by local health center doctors, with support from PCI for the training and provision of the initial supply of drugs.

D2. A total of Rp 258,200 (US$ 121) was used to establish the RDFs, including training and transport costs, and the initial supply of drugs. The local health centers provided Rp 75,000, with the balance coming from PCI.

Only incomplete information is available regarding the revenues and profits received by the RDF *kaders*. It is not possible to estimate the amount of costs recovered during the project, or the percentage of project costs this represents.

D3. As stated earlier, the cost recovery activity was only a small pilot scheme, and it apparently had a negligable influence on the project area and PCI's reputation in the community.

D4. With the limited revenue and profit data available, it is not possible to make a determination as to the success or failure of the RDF scheme.

D5. This RDF was a very small scheme involving only four kuders and US$ 121. As a result of other project priorities, little effort was put into monitoring the RDF to determine its profitability. The only relevant lesson might be that schemes like this should either be monitored or not introduced at all, since the purpose of a pilot scheme is to provide feedback on the feasibility of such an approach.

E. Household Income Generation

El. In early 1994, the project implemented a pilot income-generating (IG) scheme targetted toward the Posyandu and the kaders, rather than households. The objectives of the IG scheme were to increase the income and decrease the drop-out of kaders; and to increase the attendance of mothers and children at the *Posyandu*. A portion of the profits are intended to be given to the *Posyandu* to purchase food for nutrition demonstrations and for food supplementation for

malnourished children. The scheme was introduced in four sub-districts:

- Batang Tuaka sub-district. A loan of Rp 250,000 (US$ 117) was given to each of four Posyandu kuders, representing four villages. The kuders were to use the money for various income-generating activities, and repay the original amount, which will then be given as a loan to another kader. The fund is under the control of the sub-district PST, and will be supervised by Yayasan Utama.

- Cerenti sub-district. A loan of Rp 300,000 (US$ 141) was given to each of five Posyandu kaders to use for IG purposes for six months. As with Batang Tuaka, the repaid loans will be re-circulated to other kaders. The money is under the control of the sub-district PST, and will be supervised by Yayasan Utama.

- Tandun sub-district. In this sub-district, one Posyandu kader received a loan of Rp 1,500,000 (US$ 703), to be repaid after six months. The fund is under the control of the sub-district PST, and will be supervised by Yayasan Utama.

- Rupat sub-district. PCI gave one female goat, worth approximately Rp 100,000 (US$ 47), to each of 20 Posyandu *kaders* in this sub-district. The kader is to keep the goat for six months. If, during this time, the goat delivers a kid, the kid belongs to the kader. After six months, the goat is passed to another kader in the area, to try her luck. However, if a kader does not serve at the Posyandu for three consecutive months, her goat will be taken and given to another kader. The goats are under the control of the Village Head, the health center doctor and the sub-district PST. The scheme will be supervised by Yayasan Utama.

E2-E3. The income-generating schemes are still young, and for most of them reports have not yet been received by PC1 on the profits made by the kaders and the amounts of money given to the Posyundu. An exception is Tandun, where the kader has given a total of Rp 75,000 to six Posyandu in the sub-district, to purchase supplementary food and cover other operating expenses. Also, in Batang Tuaka, to date Rp 385,000 (US$ 180) has been repaid, and re-circulated to other kaders.

E4. Once reports have been received regarding profits to kaders and funds provided to the *Posyandu*, Yayasan Utama will be better able to assess the success of the IG scheme and draw lessons for its future activities and for other projects.

F. Other

Fl & F3. Many of the project's activities were designed and carried out with sustainability in mind, as described below. (See section C for more detail.) Some of these components have been more successful than others at establishing capability and systems likely to continue beyond PCI's CS-VII project.

- TBA training. The training of TBAs has been a central part of the project, and will contribute to the sustainability of rural health service delivery in Riau. TBAs provide antenatal and delivery care to mothers in their villages, as well as dispensing health education messages and motivating mothers to take their children under five to the Posyundu. TBAs

are respected and patronized in many villages. A total of 1,431 TBAs were trained during the project.

- TBA TOT. The project trained health center midwives to serve as TBA trainers. A total of 52 midwives received the TOT training. These midwives then trained selected TBAs in their respective sub-districts, with assistance from PCI staff. The TBA TOT capability has now been established in Riau province, making it more likely that further TBAs will be trained in the future.

- Kader training. A total of 700 Posyandu *kaders* were trained during the project, by PC1 and staff of the local health centers. These *kaders* are village residents who volunteer to help with the organization and running of the Posyundu sessions. This includes mobilizing the community to support and attend the *Posyandu*, and staffing the tables where the health services are provided. They are responsible for registering mothers and children, weighing babies and providing nutrition education, as well as assisting the health center nurses in delivering other services. *kaders* receive practical, refresher instruction from the health center staff at each Posyandu. The only constraint to their sustainability is a degree of attrition over time. The MOH will need to develop a means to continue training hders in the future.

- School *Posyandu* (PPAS) Program. The PPAS program has trained 56 primary and secondary school teachers in an innovative, school-based Posyandu education scheme that has been implemented in 26 schools, reaching 2,222 students thus far. Once trained, teachers can continue to educate future classes using the PPAS curriculum.

- Other social marketing. The Posyundu Radio Quiz program was created by PCI, and quiz episodes are broadcast by the Radio of the Republic of Indonesia (RRI) every two weeks. During the CS-VII project, 27 Posyundu radio quiz shows were produced and broadcast throughout the province. The staff of Yayasan Utama plans to continue designing the quiz episodes, and RRI has agreed to continue broadcasting them at no charge. Likewise, the newspaper crossword puzzles, articles and advertisements should continue to appear, with Yayasan Utama designing them and the two provincial newspapers, The Riau Post and Genta, publishing them gratis.

- Local NGO development. In Riau, a core of PCI staff have formed Yayasan Utama, officially registered the organization, and identified a board of directors. Already Utama has implemented a number of projects, with support from PCI. During final evaluation interviews with MOH staff, it was clear that they respected Utama's abilities, and intended to continue working with them in the future.

F2. The Detailed Implementation Plan states two objectives which would focus the project's efforts on sustainability. These objectives, and the progress made toward achieving them, follow. The DIP says the project will focus on sustainability by:

1. ***"building the skills of staff, traditional birth attendants (TBAs), and Community Health Volunteers (kaders)*** who will continue to be employed by the Ministry of Health and supported by the communities;"

As we have seen, the project provided training to a total of 52 MOH staff midwives; 1,431 TBAs; and 700 Posyandu *kaders*. While the TBAs and *kaders* are not employed by the MOH, the final evaluation found that they are generally supported by the members and leaders of their communities.

2. ***"initiating systems which will enable the MOH and community outreach activities to function more efficiently."***

The training of trainers (TOT) program has enabled the MOH, through its health center midwives, to improve community outreach by training TBAs. A system for supervising these TBAs and collecting routine health information was also introduced, although it has not been effective in many villages.

The system of *Posyandu* supervision utilizing PSTs and a monitoring form has not been successfully implemented in most areas, as discussed previously. However, many village-level PSTs appear to be more active in mobilizing their communities to attend the *Posyandu*.

The DIP also presents four sustainability indicators to be used to track progress. These indicators, and the progress made toward reaching them, are as follows:

1. ***"The number of trainings for Posyandu*** Supervision Teams **(PSTs)** in all project sites;"

Four training workshops were held at the district level; 29 at the sub-district level; and 45 at the village level. At these workshops, a total of 145 district PST members (725% of the plan), 455 sub-district PST members (168% of the plan), and 1,425 village PST members (108% of the plan) were trained. The project has clearly exceeded expectations in this regard.

2. ***"The number of PSTs which hold meetings at least three times a year to plan their activities, and discuss implementation;***

The Provincial PST has been able to hold monthly meetings, with assistance from PCI. However, since the team members are senior officials in the ministries, the time they have available to devote to other Posyandu monitoring activities is quite limited.

The district PST members in Kampar and Indragiri Hilir districts said that their teams meet every one to three months. They were not clear, however, as to the purpose and function of the PSTs. No information was available on the frequency of meetings held by the PSTs in Indragiri Hulu and Bengkalis districts.

At the sub-district level, most PSTs are not active, and do not hold meetings at least three times per year. At the village level, the level of activity was quite variable, with some PSTs meeting regularly and actively promoting the *Posyandu*, and others not making an effort. No information was available on meeting schedules or records for individual villages.

3. ***"The establishment of one new local NGO consisting of PCI's current employees and the number of trainings and signing of agreements to transfer some of PCI's PST activities to four identified local NGOs (one in each district);"***

As detailed in section C5, Yayasan Utama was established and and registered as an official NGO, and has taken over responsibility for several functions begun under CS-VII. They have also initiated their own programs, independent of the CS-VII project. PC1 decided to drop the strategy of working with four district NGOs and transferring activities to them. Instead PCI chose to focus its NGO-strengthening efforts more closely and intensively on Yayasan Utama.

4. ***"The number of sub-district PSTs employing the PWS monitoring system."***

The final evaluation found that most PSTs do not use any monitoring system, whether PWS or form F-l, as described in section IC1d. Instead, *Posyandu* monitoring is done by the health center staff. In some areas the information collected is given to the sub-district PST, but the PST does not use the information.

Sustainability-promoting activities which were unplanned in the original project design include the school *Posyandu* program (PPAS), the radio quiz shows, and the newspaper promotions. These were also some of the more successful programs implemented.

III. EVALUATION TEAM

A1. The final evaluation team included the following members:

Dr. Tanya Inalot Mokoginta, Staff member, Directorate of Community Participation, MOH/Jakarta

Mr. **Mansyur** Pawata, Director, SINTESA (Indonesian NGO based in S.E. Sulawesi)

Mr. Jeffrey Billings, Technical Support Officer, Project Concern International/San Diego

A2. All team members participated equally in the preparation of the final evaluation report. The draft report was written by Jeffrey Billings and circulated to the other team members for comment and editing. Their comments were then incorporated into the final draft of the report.

APPENDIX 1

FINAL PIPELINE ANALYSIS

CS VII - Riau Pipeline
09/01/91-09/30/94
Grant # PDC-0500-A-00-1042-00

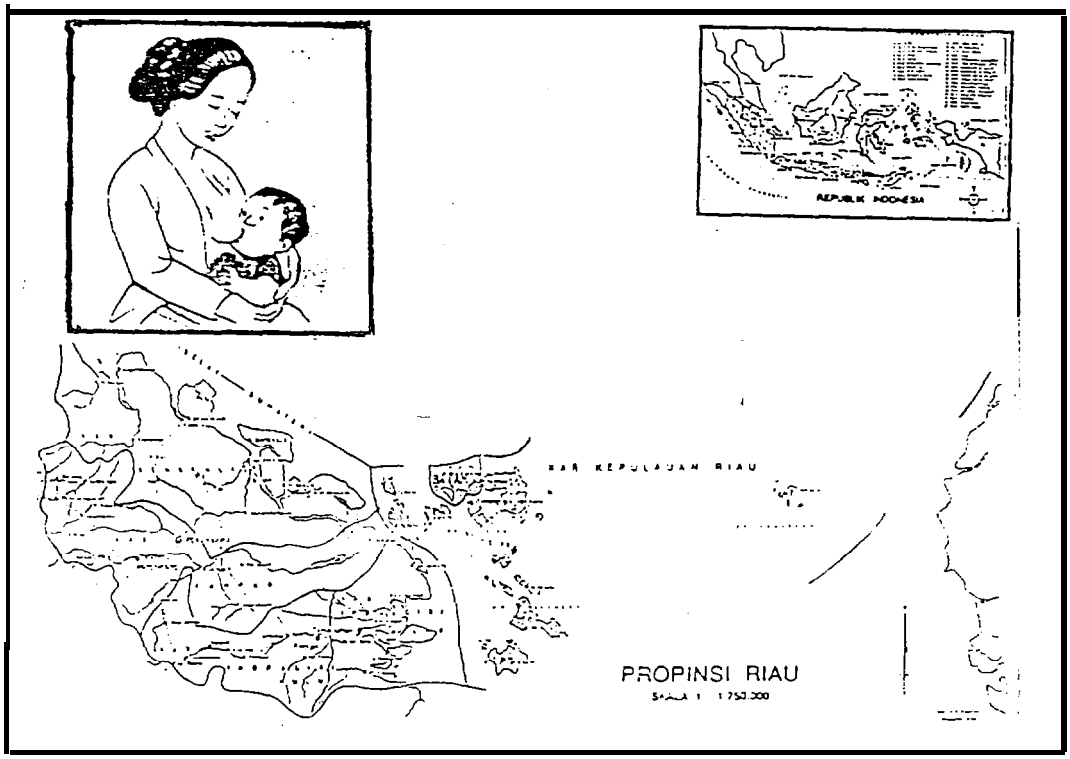
	ACTUAL EXPENDITURES TO DATE (09/01/91-09/30/94)			TOTAL BUDGET (09/01/91-09/30/94)			REMAINING OBLIGATED FUNDS		
	AID	PCI	TOTAL	AID	PCI	TOTAL	AID	PCI	TOTAL
Salaries & Benefits	202,950	511,541	714,491	211,154	73,200	284,354	8,204	(438,341)	(430,137)
Consultants	4,662	0	4,662	39,800	6,493	46,293	35,138	6,493	41,631
Travel/Per Diem	138,937	6,006	144,943	46,609	0	46,609	(92,328)	(6,006)	(98,334)
Equipment	1,706	50,425	52,131	0	19,690	19,690	(1,706)	(30,735)	(32,441)
Supplies	12,058	11,293	23,351	3,896	3,000	6,896	(8,162)	(8,293)	(16,455)
Other Direct Costs	48,836	415,675	464,511	74,003	21,000	95,003	25,167	(394,675)	(369,508)
In-Direct Costs	118,683	286,579	405,262	99,910	32,832	132,742	(18,773)	(253,747)	(272,520)
Total Expenses	527,832	1,281,519	1,809,351	475,372	156,215	631,587	(52,460)	(1,125,304)	(1,177,764)

APPENDIX 2

FINAL SURVEY REPORT

FINAL SURVEY REPORT
CHILD SURVIVAL VII PROJECT – RIAU, INDONESIA

May, 1994



A. MANAN, MD. MPH
Project Director, PCI/RIAU

Project Concern International
Riau Office
Phone & Fax : (0761) 37645
Pekanbaru 28001

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ACKNOWLEDGEMENTS

I would like to thank the following persons who participate in the preparation and conduct of this survey:

1. Dr. Salohot, Head of the Provincial Ministry of Health for her support and for her administrative and arrangement of permits for the survey
2. Steve Robinson, MD.,MPH.,PhD., for his advice.
3. Drs. Asmar Saleh, Chairman of the Provincial Posyandu Supervision Team, and the members of Provincial PST for their support.
4. Heads of District Health Services: Dr. H. Fattah Lingga, Bengkalis: Dr.H.Thamrin Manaf, Kampar: Dr. H. Zaenal Abidin, MPH, Indragiri Hulu; Dr. Rusdi M. Nur, Indragiri Hilir.
5. District and Sub-district Posyandu supervision teams.
6. PCI staffs; all involved.

7. Supervisors:
   a. Yufrizal Putra (PC1 staff)
   b. Edy Guntur S.E. (PC1 staff)
   C. M. Saleh (PC1 staff)
   d. Indrowirasto S.E. (PC1 staff)
   e. Ismail Nasution (PC1 staff)
   f. Harliyanti Jon SH (PC1 staff)
   g. Herlina S.E. (PCI staff)
   h. Afdal (PC1 staff)
   i. Ir. Ida Roslina (PC1 volunteer)

8. Surveyors:

a. Marjoko Santoso Bsc.	(MOH District of Bengkalis)
b. Imam Subchi Bsc.	(MOH District of Bengkalis)
c. Elmi Rizal	(MOH District of Bengkalis)
d. Surip	(MOH District of Kampar)
e. Alamsyah	(MOH District of Kampar)
f. Helmi	(MOH District of Indragiri Hulu)
g. Gusriandri	(MOH District of Indragiri Hulu)
h. Riskomara SKM	(MOH District of Indragiri Hilir)
i. Hayandi Bsc	(MOH District of Indragiri Hilir)

Without their participation and contributions, this final survey would not be presented as it is. I believe that their contributions will have a significant impact on the health development of Riau in particular and Indonesia in general.

Pekanbaru, May 20, 1994

I. EXECUTIVE SUMMARY

The objective of this Final survey was to obtain information on the health knowledge and practices of mothers with children under two years in the project site of PC1 Riau in four districts, 27 subdistricts of Riau Province before PC1 Riau end the Project of CS VII in Riau and compared it with the information from baseline survey which had been conducted in October 1991.
This survey was achieved through cooperation between Project Concern International Riau and personnel from the Government of Riau - i.e. the Provincial Posvandu Supervision Team, under the authority of the Indonesian Ministry of Health.

The questionnaires was the same as that in base line survey, initially designed at the PVO Child Survival Support Program (PVO CSSP), Institute for International Programs of the Johns Hopkins University School of Hyqiene and Public Health, in consultation with PCI/Indonesia - Riau. The questionnaire was further refined in field tests in Riau and translated into Indonesian.

Since in this survey we have also to evaluate the immunization coverage, which usually covered the children 12 - 13 mos old, we used separate form and looked for addition children 12 - 23 mos old up to seven in each cluster.
Specifically for the immunization coverage, the data were collected from Road to Health Card (KMS) and Yellow book which are available at Health Center or at Posyandu (Integrated Health Post at the village level).
Thirty cluster site villages were located as per the standard WHO method (Henderson and Sundaresan, 1982;Galazka and Stroh, 1986), so that the number of cluster sites in each sub-district was proportional to the population of the sub-district. All interviewing was done house to house until every house in the village was covered, if no adult member of the- household was present the interviewer proceed to the next house and did not return. All the interviewers were from District Health Office and the Supervisors were from staffs of PC1 Riau. The training was conducted before the implementation of the survey so that the PCI/staffs and the interviewers can carry out the survey on a appropriate way.
The implementation of the survey was accomplished in 10 days, from May 5 to May 15, 1994. All the data were collected and entered into the computer using the Epi Info 5 program.

The result obtained in this survey in some points were slightly higher than in the baseline survey, and the target for CS VII project as stated in the proposal were achieved. However the findinqs were still lower than the estimated national average, specifically for the immunizations. The children who received all doses needed at the correct time, is still very low, although the first contact to the vaccination (BCG and DPT1) is rather high (57% and 56%).

Some important findings in the final survey are: a rate of exclusive breastfeeding was 30,7% for the first four months of life, while the national average is estimated to be 36%.
46,4% of children at the area of survey had KMS (Road to Health Card), an indicator for the children who attended Posyandu. 48% of mothers interviewed treated their children with ORALIT (sugar salt solution) when they had diarrhea, and 54,4% of mothers interviewed took their children to Hospital, Health Center or Posyandu when their children had diarrhea, while point prevalence of diarrhea was 22,6%. Only 28%% of children age 12 - 24 months had vit.A recorded in their KMS. The national target for vit.A is 70 - 80% by the year 1994.

73,3% of mothers interviewed could read and 26,7% of mothers cannot read. 76,2% of mothers did not work away from home.
54,6% of mothers when interviewed knew that the pregnant mothers need two TT injection, while when examined in the Maternal Health Card, 62,5% recorded two TT injection. PC1 has printed and distributed 35,000 Maternal Health Cards in the area of CS VII project. Only 21,8% of mothers interviewed had Maternal Health Card.
49,8% of mothers interviewed reported that train TBA attended their delivery, and 25,1% of mothers were helped by health worker(physician, midwife-nurse).

II. INTRODUCTION.

A. Background

The province of Riau consists of seven districts (5 Kabupatens and 2 Kotamadyas) and 76 sub-districts located on the east side of the island of Sumatra. It contains small islands spread over vast areas; the mainland area is low lying, comprised mainly of swamp traversed by large rivers, leaving many vilages inaccessible during the rainy season. PC1 Riau began to work in Riau in 1989,in seven districts and 37 sub-districts through CSIV Project and ended in August 1991.
This CSVII began to work in September 1991 in four districts and 27 sub-districts (24 defined sub-districts and three satellite sub-districts). These new sub-districts are in general more isolated than the sub-districts targeted in the CSIV project.

Project CSVII activities include:

Immunization	60%
Prevention of High Risk births	20%
ORT	10%
Nutrition	5%
Vitamin A	5%

The Ministry of Health during Pelita V and Pelita VII gives the priority on their health activities to lower the IMR and MMR through the Posyandu program. The Posyandu is an integrated health post which aims to provide maternal and child health outreach servic.i.3 to every village in Indonesia. It is organized by the community and serve by community volunteers or kaders, with the provision of technical assistance from health center staff. Posyandu is intended to be implemented monthly, but logistical factors and lack of support and supervision in remote areas impede the delivery of health services in Riau.

B. Objective of the survey.

The objectives of the survey is to obtain health information in order to evaluate the Child Survival VII Project in Riau Province. The survey also aims to provide the local Government and the Provincial Posyandu Supervision Team with information to assist them in allocating resources for future programs to achieve maximum benefits.

C. Schedule of Activity

April 27 - 29	Final preparation of the survey
May 2	Supervisors departed Pekanbaru to 4 districts.
May 4	Training of the surveyors and field test of the questionnaire.
May 5 - 15	Implementation of the survey in 30 villages (clusters) of 27 sub-districts of Riau Province.
May 16 - 20	Tabulation of survey results and data entry into EPI/INFO 5.1b software program.
May 21 - 30	Composing of survey draft report.
June 6, 1994	Discussion the result with the PC1 staffs
June 13,1994	Feedback to Provincial Ministry of Health Personnel in Pekanbaru

III- METHODOLOGY

A. The Questionnaire

The questionnaire , which contains 47 questions, was designed to collect information from mothers of children under 24 months of age, and which would be relevant for planning and evaluation of the pcI/Indonesia - Riau Child Survival project. The questions were developed and selected by the staff at PVO CSSP, with the assistance Of US and International experts for the various intervention areas, and in cooperation with PCI/Indonesia - Riau field staff.

The first two questions ask about the age of mothers and children, and mother's education: questions 3 - 6 collect data regarding mother's employment, literacy, and who cares for the child when the mother is away from home: questions 7 - 16 deal with breast-feeding and other nutrition practices; questions 17 - 20 ask questions concerning the child's attendance at growth monitoring sessions and the distribution to the child of Vitamin A supplements; questions 21 - 28 refer to mother's response to diarrhea1 disease and management of the child with diarrhea: questions 29 - 33 concern the immunization status of the child; and finally, questions 34 - 47 are about pre-natal care and family planning.

The questionnaire was originally written in English and sent to the PCI/Riau office, and later translated into Indonesian for comparison and further customization to the appropriate Riau nroject area.
Besides the questionnaire mentioned above, the survey also used separate forms for evaluation immunization coverage.(see annexes).

B. Determination of sample size

Sample sizes were calculated with the following formula:

$$n = z^2 (pq)/d^2$$

where n = sample size: z = statistical certainty chosen: p = estimated prevalence/coverage rate/level to be investigated: q = 1 - p; and d = precision desired.

The value of p was defined by the coverage rate that needed the largest sample size (p = .5). The value d was depends on the precision, or margin of error desired (in this case d = .1). The Statistical certainty was chosen to be 95% (z = 1.96). Given the above values, the following sample size needed was determined to be:

$$n = (1.96 \times 1.96)(.5 \times .5)/(.1 \times .1)$$
$$n = (3.84)(.25)/.01$$
$$n = 96$$

The survey used 30 clusters technic. In order to compensate for the bias, experience has shown that a minimum sample of 210 should be used given the values of p, d, and z above (Henderson, et. al.,1982) . In this case, a sample size goal of 240 (8 per cluster) was set so as to ensure the minimum of 210 would be obtained.
The CSVII project is also to calculate the immunization coverage, and normally only applies to children 12 - 23 months old.In reality we need at least 200 children 12 - 23 months in order to be statically correct for immunization coverage. In the base-line survey we found that only about 38% - 40% of all children under two are in this category (12 - 23 mos); thus for a survey of 240 we were only able to get 90 children 12 - 13 mos old. To face this problem we need addition 3 - 4 children 12 - 23 mos old in each cluster.To say in another word that we need 7 children 12 - 23 mos old in each cluster.
For this reason we used a separate form for recording this data, separate from all the questionnaire data (see annexes).

C. Selection of the Sample

The sample consisted of 240 women with children 0 - 23 months of age in 27 subdistricts in Riau Province, Indonesia. 8 women were selected in each of 30 randomly selected cluster sites (30 desa were chosen) following the process described in The EPI Coverage Survey training manual (WHO, Geneva, Oct. 1988).

Once the survey teams reached the designated cluster site (desa), the cluster was subdivided further into RTs. RTs are local administrative units which are usually slightly large than the required number of households to be surveyed per cluster. One RT was randomly selected as the community within each desa to be surveyed. The initial household surveyed within the RT, as well as the direction from the initial household, was also randomly selected.

D. Training of supervisors and interviewers.

PCI/Riau staff had pre-selected 9 supervisors and 9 interviews for training.
The training of supervisors took place in Pekanbaru for one day by PC1 staff. One day training was considered enough for the supervisors since they had already experienced in conducting previous survey. Training for district members took place in each of the district for one day and conducted by PCI technical staff. The content of this training consisted of an explanation of the survey and basic surveying principles, instruction on site selection, explanation of the coding, practice implementing the survey (both classroom and field trials).

E. conduct of the survey

The survey was conducted over 10 consecutive days: May 5 - May 15. As a routine, the Survey team met with the heads of the Health Center and with the village leaders to advise them of the purpose of the survey and to request their assistance in advising residents of the survey. In each village (cluster), Posyandu cadres or village officials accompanied the survey team throughout the duration of their work.

Thirty survey areas had been pre-selected prior to the training; with the teams to survey each area had also been pre-selected. Each district consisted of two teams, except in district of Bengkalis, it consisted of three teams. The supervisors of each team were responsible for the selection of the actual community (RT) surveyed, as well as the starting household and survey direction. The supervisors observe at least one complete interview by each surveyor each day. Each questionnaire including the immunization coverage form was checked for completeness before the survey team left the survey area, so that in the case of missing or contradictory information, the mother could be visited again in the same day.

G. Method for Data Analysis

All data were collected and entered to computer using Epi Info 5.1 program by three PC1 staffs.

IV. RESULTS

A total of 245 questionnaires were completed, 6 questionnaires were removed from the analysis, because six children of these questionnaire were older than 23 months.

IDENTIFICATION

1. The mean age of mothers in the survey was 26,5 years. The youngest reported age was 15 and the oldest reported age was 46. Table I summarized the composition of the mother age:

Table I. Composition of mother age surveyed

AGE	NUMBER
15 - 19	18
20 - 24	91
25 - 29	60
30 - 34	30
35 - 39	30
40 - 44	8
45 - 49	2
TOTAL	239

From 239 mothers surveyed 15 were pregnant and 224 were not pregnant. I

2. 121 of the 239 mothers surveyed reported the age of their children as being between the ages of 0 and 11 months. 118 of ,739 children were reported as being between ages of 12 - 23 months. The mean ages of all the children were 11,3 months.

MOTHERS EDUCATION AND OCCUPATION

3. 117 of mothers surveyed reported having a primary education and that they could read (49%). 58 of 239 mothers reported having a secondary or higher level of education. Therefore, 175 of 239 mothers (73,3%) are reporting that they can read.
30 mothers (12.6%) reported having no education, and 34 mothers(14.2%) reported having a primary education but no reading ability.

4. 57 of 239 mothers (23.8%) surveyed answered that they worked away from home. A majority of mothers surveyed (182 of 239), therefore, are not working away from home.

5. Out of 84 mothers surveyed who did work for income generating: 8 earned income from selling handicrafts, 48 earned income from harvesting or fruit picking, and 3 from selling agricultural products. 6 mothers earned income from selling prepared foods or dairy products, 3 worked as servants, and 9 as street vendors or

shop keepers. 1 mothers reported earning income as salaried workers.

6. 20 mothers surveyed reported that relatives took care of the child when the mother was away from home. 43 mothers took the child with them when they were away from the home. 16 mothers reported that they left the child with an older child when the mother left the home. 6 mothers answered that the husband took care of the child when the mother was away. One mother said that she left the children with the servant.

BREASTFEEDING AND NUTRITION

7. 215 mothers (90%) reported that they were still breastfeeding their children. 24 mothers (10%) were no longer breastfeeding.

8. 17 of 24 mothers who were no longer breastfeeding, reported having breast-fed their children in the past. 7 of these mothers had never breastfed their children.

9. Of the 215 mothers who had breast-fed or were still breastfeeding their children, 49 mothers (22.8%) first gave breastmilk to their children within the first hour after delivery. 44 (20,5%) gave their children breastmilk from one hour to eight hours after delivery. 122 mothers did not give their children breastmilk until more than eight hours after delivery.

10. This question was tabulated by age on Epi/Info:
Of the 26 babies age 0 - 3 month, 8 babies were exclusively breastfeeding (30,8%) without getting any foods formulated in this question, 18 babies (60,2%) while they breast-fed , they were being given at least one of the food or drink categories in this question.
Of the 41 babies age 4 month to 6 month (4-6), 9 babies were exclusively breastfeeding (22%) without getting any foods or drink categories in this question.
Of the 190 children age 4 months and older and still getting breastfeeding, 10,children were still exclusively breastfeeding. while 180 children got one or more foods categories in the questionnaire.

11. This question wants to find if mothers know what they can do to ensure the supply of breastmilk to the child during the first three to four days of life. 37 of 239 mothers surveyed reported that breastfeeding as soon as possible after delivery was something they could do to keep on breastfeeding. 24 mothers (10%) avoid bottle feeding as an answer. 51 mothers(21,3%) answered that frequent sucking by the child to stimulate milk production was something they could do to keep on breastfeeding: 49 mothers(20,5%) responded with care of the nipples. 44 mothers (18,4%) didn't know what they could do to keep on breastfeeding during the first three

to four days after delivery.
130 mothers (54,45%) gave an answer" other" than one of the responses on the questionnaire. Most of them said that they took vegetables to continue to breast-feed during the first three to four days of life: and the second largest answers were to eat "medicinal herbs", the third largest was to message as things a mother can do during the first days after delivery to ensure the supply of breastmilk.

12. Of the 239 mothers surveyed, 37 (15.5%) stated that exclusive breastfeeding was something they could do during the child's first four months of life to keep on breastfeeding. 34 mothers (14,2%) answered that frequent sucking by the child was something that could be done to keep on breastfeeding, and 5 mothers answered this question with relactation. 20 mothers answered that avoiding bottle feeding was something they could do to ensure the supply of breastmilk.
102 mothers (42,7%) gave an answerer "other" than one of the responses on the questionnaire. Most of them answered that eating vegetables was something they could do to keep on breastfeeding during the first four months of the child's life. The second largest answered was taking medicinal herbs.

13. 87 out of 239 mothers (37,3%) stated that additional food to breastfeeding should be given to the child between four and six moths of age. 83 (35,3%) mothers responded that mothers should give their children food other than breastmilk earlier than four months. 45 mothers (19.3%) said that the additional food should be given after six months of age. 3!8 mothers (7,7%) did not know that they should give additional food.

14. When asked what foods should be given additional to breastfeeding, 80 mothers (33,5%) answered with food that were rich in vit A. 65 mothers (27,2%) answered with food which were rich in oil or fat, and 66 mothers(27.6%) answered with food which were rich in iron. 54 mothers (22,6%) did not know which food to give. While 104(43,5%) answered the question with something "other"than questions written on the questionnaire.

15. 81 out of 239 mothers (33,9%) stated that vit.A was the vitamin which helps to prevent "night blindness", and 158 mothers did not know which vitamin helped to prevent night blindness.

16. When asked what foods contain vitamin A in order to prevent night blindness, 130 mothers (54,4%) did not know or something "other"than the categories of food written on the questionnaire, which food contain vitamin A. 91 mothers (38,1%) responded that qreen leafy vegetables contain vitamin A, and 53 mothers (22,2%) said that yellow type fruits and vegetables contain vitamin A. 17 mothers (1,1%) stated that either meat or fish contain vitamin A. 6 mothers (2,5%) said that breastmilk as foods which have vitamin A. 9 mothers (3,8%) responded that egg yolk contain vitamin A.

GROWTH MONITORING

17. Of the 239 mothers surveyed, 111 (46,4%) had KMS "Road to Health" cards(growth monitoring, immunization, and vitamin A capsule records) for their children. 23 mothers (9,6%) reported that they had lost the card, and 105 mothers(43,9%) did not have KMS card for their children.

18. Of the 111 mothers who had KMS card for their children, 92 children (82,9%) had been weighed in the four months prior to the. survey.

19. All KMS cards had spaces to record the distribution of Vitamin A capsules.

20. Of the 121 mother who had children age O-11 months, only 54 children have KMS cards (44,6%) and only two children recording vitamin A distribution.

Of the 118 children whose age 12-23 months, only 57 children(48,3%) have KMS cards and 17 children(28%) recording vitamin A distribution.

The total number of children age 12 - 23 months, from KP questionnaire (118) and immunization forms(73) are 191. Of this 191 children 101 children had KMS cards (52,9).

DIARRHEAL DISEASES

21. 54 of 239 mothers (22,6%) surveyed reported that their children had diarrhea in the two weeks prior to the survey, and 185 (77,4%) mothers reported that their children had not suffered from diarrhea.
Diarrhea was defined as at least three consecutive loose stools.

22. Of the 54 children reported to have had diarrhea in the two weeks prior to the survey; 14 (25,9%) were reported have been given more breastmilk than usual, 25 (46,35%) were reported to have been given the same amount of breastmilk as usual, 10(18,5%) were reported to have been given less than usual. 4 mothers (7,41%) have stopped breastfeeding completely during their children's diarrhea, and one mother was not breastfeeding her child any more.

23. Of the 54 children reported to have had diarrhea in the two weeks prior to the survey: 19 children (35,2) were reported to have been given more fluids than usual, 21 children (38,90%) were reported to have been given the same amount of fluids as usual, 5 children (9,3%) were reported to have been given less than usual. 2 children (3,7%) were reported that during the diarrhea, their mothers stopped giving fluids entirely, and 7 mothers (13%) stated that they were exclusively breastfeeding before and during the child's diarrhea.

24. Of the 54 children reported to have had diarrhea in the two weeks prior to the survey: 3 children (5,6%) were reported to have received more solid/semisolid food than usual, 19 children (35,2%) were reported to have received the same amount of solid/semisolid food than usual. 14 children (25,9%) were reported to have received less than usual, 6 children (11,1%) were reported that the mothers stopped giving the solid/semisolid food. 12 children (22,2%) were reported had only breastfeeding during they suffered from diarrhea.

25. Of the 54 children reported to have had diarrhea in the two weeks prior to the survey; 25 children (46,3%) were reported to have been given OFZALIT, 9 children (3,8%) have been given anti-diarrhea medicine and six children (2,5%) have been given LGG (sugar salt solution, made by mother). One child has been given "home fluids". 10 mothers(18,5%) were reported giving their children no treatments. 17 mothers(31,5%) were reported to give "other"than one of the questions on the questionnaire.

26. All the mothers (239) were asked what signs or symptoms would cause them to find advice or treatment when their children got diarrhea: 57 mothers (23,3%) stated that when their children vomited, 78 mothers (31,8%) stated that they did not know. 52 mothers (21,2%) said that when their children got fever. 32 mothers (13,1%) stated that when there were sign or symptom of dehydration i.e. dry mouth, sunken eyes, or decrease urine output. 52 mothers (21,2%) said that when their children showed sign of weakness or tiredness. 30 mothers (12,2%) stated when "decrease appetite". 14 mothers (5,7%) said when there were blood in stool. 67 mothers (27,3%) responded with a sign or symptom "other" than one cf the questions in the quzstionnaire.

27. 130 of 239 mothers (54,4%) responded that taking their children to Hospital or Health Center/Posyandu when they got diarrhea. 37 mothers (15,5%) responded that they did not know what action they should do when their children had diarrhea. 38 mothers (15,9%) stated that they gave their children more water to drink. 7 mothers (2,9%) reported that giving smaller and more frequent feeds. 7 mothers(2,9%) statedthatwithholding fluids and 2 mothers stated withholding foods was an important action. While 90 mothers responded "other" than one of the responses on the questionnaire. Most of them stated that giving oralit and traditional medicine.

28. 101 of 239 mothers (42,4%) stated that they did not know what were actions for a mother to take when their children were recovering from diarrhea. 69 mothers (24,7%) responded that giving their children smaller and more frequent feeds was an important action to take. 39 mothers (16,3%) stated that giving more to eat than usual. 24 mothers (10,%) stated that giving high-calorie foods was an important action. 39 mothers (16,3%) responded with something "other" than the action listed on the questionnaire-

IMMUNIZATION

29. Of the 239 mothers interviewed, 148 (60,4%) stated that their children had been given immunizations, and 96 mothers (39,2%) said that their children had not received any immunizations. One mother (0,4%) stated that she did not know if her child received any immunization.

30. When asked at what age their children should receive the measles vaccine, 49 mothers(20%) answered with 9 months and 196 mothers (80%) answered with another age or stated that they did not know when their children should receive the measles vaccine.

31. 68 (28,6%) of 239 mothers interviewed, answered that the reason why pregnant women needed to vaccinate with the tetanus toxoid vaccine was to protect both the mother and the newborn against tetanus. 5 mothers (2,1%) responded that the vaccine would protect only the mother and 24 mothers (10,1%) said that the vaccine would protect only the infant. 141 mothers (59,2%) said that they did not know the reason why pregnant women needs to be vaccinated with the tetanus toxoid vaccine.

32. 66 of the 244 mothers interviewed (27%) knew that pregnant women should receive two tetanus toxoid injections. 13 mothers (5,3%) stated only one tetanus toxoid injection, while 67 mothers responded that pregnant women needed more than two tetanus toxoid injections. 95 mothers(38,9%) responded that they did not know how many times pregnant women should get the tetanus toxoid injection. Three mothers (1,2%) stated that pregnant women need not to be vaccinated.

33. In this survey to evaluate the coverage of the immunization, besides the KFP questionnaire we also used separate forms to add the sum of 12 to 23 mos children on the questionnaire to at least 210 children, the sum that would be appropriate to evaluate the coverage of the immunization. If the child did not have KMS card, we also looked up the name of the child in BUKU KUNING (yellow book) at Health Center or Posyandu. Buku Kuning is a book for registered the child who got the immunization but did not have KMS card. This book is available at Posyandu or at Health Center-So in this case we evaluate the coverage of the immunization, by looking in XMS and Yellowbook for the children age 12 to 23 mos. For the children age 0 to 11 mos we only looked at the KMS card-children who did not have KMS and Yellow book (children 12-23 mos) were assumed to have never receive a DPT, Polio or Measles immunization.

As the result we have 210 children age 0 - 11 months and 191 children age 12 - 23 months.

54 of 121 children age 0 - 11 mos had KMS (44,6%)
101 of 191 children age 12 - 23 had KMS (52,9%) and 14 children had Yellow book.

when the frequency distribution of immunized children cross tabulated with age, the time they got the vaccination, the interval DPT123, Polio123 the result as follow:

80 of 191 children age 12 - 23 mos (41,7%) received BCG, DPT123, polio123 and measles, without considering the age of the children and the interval of DPT123 and Polio123.

of these 80 children age 12 - 23 months 71 children (36%) had received BCG, DPT123, Polio123, and measles before their first birthday, without considering the interval of DPT and Polio, and the age when they got the vaccination.

Of these 71 children, when we used the criteria that the children got the measles at the age 9 month to 12 month, without considering the interval of DPT and Polio, and the age when they got BCG, DPT and Polio, there were only 44 children (23%) met this criteria.

Of these children age 12 to 23 months, only 23 children (12%) got the complete vaccination(BCG, DPT123, Polio 123, and measles, with the criteria: got measles vaccination at the age 9 to 12 month, the interval of DPT123 and Polio123 three to 6 weeks.

MATERNAL CARE

34. 24 of mothers interviewed (10%) had maternal health card, 28 mothers(11,7%) said that they had lost their maternal health card. While 187 mothers(78,2%) said that they didn't have maternal health card.

35. 18 of 24 mothers who had maternal health card had at least two TT injections. 9 mothers had one injection, and 2 mothers not at all.

36. All Indonesian MOH maternal health cards, have a space to record antenatal visits.

37. Of the 24 mothers who have maternal health cards-, 6 mothers had (26,1%) made four or more antenatal visits to health worker. Six mothers had made three antenatal visits, 7 mothers had made two antenatal visits, and 3 mothers had made one antenatal visits, while one mother did not do antenatal visit.

38. 15 of 239 mothers interviewed (6,3%) stated that they were pregnant at the time of the survey.

39. Of the 224 mothers who were not pregnant at the time of the survey, 159 mothers (71.6%) did not want to pregnant in the next two years, 50 mothers (22,3%) said that they want to have a new baby in the next two years. While 15 mothers (6,7%) were not sure if they did or not.

40. Of the 174 mothers who did not want to pregnant or were not sure in the next two years, 105 mothers stated that they were using some method to avoid or postpone getting pregnant.

41. The 105 mothers who stated that they were using some method to avoid or postpone getting pregnant, responded with the following method:

39	(36,8%)	getting injection
33	(31,1%)	using contraceptive pills
8	(715%)	using IUD
7	(6,6%)	using contraceptive Norplant
3	(2,8%)	using rhythm method
1	(0,9%)	exclusive breastfeeding
1	(0,9%)	abstinence
4	(3,8%)	coitus interruptus
10	(9,4%)	other

42. 157 of 238 mothers interviewed (66%) stated that a pregnant woman should see a health professional in the first trimester of pregnancy, 47 mothers (19,7%) said "in the second trimester of pregnancy". 9 mothers (3,8%) stated that a pregnant woman should examine first in the third trimester. 5 mothers (2,1%) stated that a pregnant woman no need to see a health worker, while 20 mothers (8,4%) stated that they did not know when a pregnant woman should first see a health professional.

43. When asked what foods are good for pregnant woman to eat to prevent anemia, 146 mothers (61,1%) said leafy green vegetables which were rich in iron. 92 mothers (38,5%) mentioned proteins rich in iron (eggs, fish, meat). 59 mothers (24,7%) stated that they did not know what foods help prevent pregnancy anemia, while 74 mothers (30,6%) responded other than a type of food written on the questionnaire.

44. 175 of mothers surveyed (73,2%) did not know how much weight a woman should gain during pregnancy. 22 mothers (9,2%) stated that a woman should gain between 10 and 12 kilos during pregnancy. 6 mothers mentioned that a woman should gain the same amount of the baby weight. 36 mothers (15,1%) responded "other" than the questions written on the questionnaire.

45. 175 mothers interviewed (73,2%) reported that they visited either Hospital, Health Center, clinic, during their pregnancy for antenatal care, while 64 mothers (26,8%) did not.

46. 92 mothers surveyed (38,5%) reported that they ate more than usual during pregnancy. 97 mothers (40,6%) reported that they ate the same amount as usual during pregnancy, 48 mothers (20,1%) mentioned that they ate less than usual, while 2 mothers (0,8%) stated that did not remember how much they ate during pregnancy.

47. 119 of 239 mothers surveyed (49,8%) stated that a trained TBA cut the umbilical cord at delivery. 53 mothers (22,2%) stated that untrained TBA cut the cord. 60 mothers (25,1%) stated that health worker(physician, midwife, nurse) cut the cord. 4 mothers (1,7%) said that family member cut the cord, while 3 mothers (1,3%) stated that she herself cut the cord.

V. DISCUSSION

IDENTIFICATION

The number of women surveyed were 245. After entering the data into the computer using the Epi Info 5 program, only 239 met the Criteria-The other 6 mothers have the children above the age of 23 months,so only 239 mothers included in the analyze. The youngest mother age was 15 and the oldest was 46 years old. The number of mother age 15 to 19 years were 18, the number of mother age 20 to 29 years were 151, and the number of mother age 30 to 39 years were 60, while 10 mothers have age above 40 years old.

EDUCATION/OCCUPATION

175 of 239 mothers(73,3%) interviewed are reporting that they can read. 12,6% of the mothers have no education and cannot read, while 14,2% of the mothers having a primary education but no reading ability. This means,that if we combine these two categories, 64 mothers (26,7%) are illiterate.

BREASTFEEDING/NUTRITION

Almost all mothers surveyed breast-fed their children. Of these mothers only 49 mothers(22,8%) first gave breastmilk within the first four hour after delivery. The rest of mothers who breast-fed their children first gave breastmilk within four hour and eight hour or more than eight hour after delivery.

8 of 26 mothers interviewed who had children age 0 - 3 months (30,8%) were exclusively breastfeeding. The national rate for exclusive breastfeeding during the first four months of life is estimated to be 36% .At the baseline survey the rate were 28,6%. It seems that it will take a long time to increase the rate of exclusive breastfeeding among mothers in the rural area as well as in the city. It will a great challenge for the Ministry of Health. Many mothers need to hear this massage.

Only 9 of 41 children age 4 to 6 (22%) month were still exclusive breastfeeding, this means that 88% of the children of these age had begun to get foods other than breastmilk.
Approximately 65% of the children aged 3 months or older were being given foods which were rich in vitamin A and protein. 40% of mothers were giving their children foods high in calories (fats and sugars). The MOH health message in "Guidelines for a Healthy Life" is for mothers of children under three years of ag to add fats and oil to their children's food, and to give foods rich in vitamin A. Many mothers still need to hear this message. While many mothers are giving their children foods which are rich in vitamin A, most mothers could not specifically name which foods contain vitamin A or that vitamin A is the vitamin which prevents"night blindness". Most mothers did not know what actions they could take to help

ensure the supply of breastmilk. The MOH message is that to ensure the supply of breastmilk, the mother should allow frequent sucking, should exclusively breastfeed for the first four months of life, and hence avoid bottle feeding of the child. Approximately 90% of mother surveyed did not mention these actions as ways to ensure a supply of breastmilk. Many interviewers and supervisors felt that mothers may not have understood the questions regarding this message (11 and 12). This may be an indication that this message is not being delivered in an appropriate manner, if the mothers do not understand or recognize the question.
If compared with the baseline survey the finding in this survey is nearly the same or to say in other way, the difference is not so significant.

GROWTH MONITORING

111 of mothers surveyed (46%) had KMS cards for their children. Of these children, 92 children (82,9%) had been weighed at least once in the four months prior to the survey. The MOH message for mothers to have their children under the age of three years weighed every month at POSYANDU and to record this weighing on the child's KMS card.

Of 57 children age 12 - 23 month who had KMS, only 17 children (28%) recording vitamin A on their KMS.
Ministry of Health policy is to give one 2000 i.u vitamin A capsule semi-annually to children after they reach the age of 12 months. The MOH target rate for vitamin A capsule distribution is 70 - 80% by the year 1994.

DIARRHEAL DISEASES

54 of 239 mothers (22,6%) surveyed reported that their children had diarrhea in the two weeks prior to the survey. The WHO manual for CDD surveys cites 20% as a normal finding for children under 5 years of age. At the baseline survey that figure was 15%. It is difficult to compare this figure if there is any improvement or worsen because the difference of the figure is not so high. The prevalence of diarrhea at the project site usually depend on season, in dry season the outbreak of diarrhea usually is higher than in the rain season, due to shortage of water.

25 of 54 children had diarrhea(46,35%),were reported had been given the same amount of breastmilk as usual,while 14 mothers (25,9%) gave more breastmilk and 10 mothers (18,8%) gave less breastmilk than usual, 4 mothers(7,4%) stopped breastfeeding. These percentages suggest that most women know to give the same or more breastmilk during the child's diarrhea. However, many women need to be educated to give more foods during their child's diarrhea.

25 of 54 children had diarrhea (46,6%) were reported have been given ORALIT, and 6 children (2,8%) have been given LGG. It is interesting to note that in the baseline survey the number of children who got ORALIT was 28% and the number of children who got the LGG was 20%.
The increase of using ORALIT in the final survey should be further examined.

130 of 239 mothers (54,4%) responded that they took their children to Hospital or Health Center/Posyandu to get advice or treatment for their children when they got diarrhea. This suggesting that Health Center or Posyandu had been widely known by the community in rural area.

IMMUNIZATION

As mentioned before that the coverage immunization evaluation in this final survey, besides the KP questionnaire we used separated form to add the number of children age 12 - 23 months of age up to 210. After entering into the computer, only 191 children were met the criteria.

In CS IV and in the baseline survey of CS VII the criteria for complete immunization was only: when the child get complete immunization (BCG, DPT123, P123, and measles) before they reach one year of age, without considering the age they got the vaccination, the interval of DPT123 and Polio 123, and the age of getting the measles vaccination.

As we know that the criteria for the complete immunization is not only that the children get the complete immunization before they reach the age of one year, but we must consider the interval of DPT and Polio, and also the age of getting measles vaccination.

In regarding this criteria in this final survey I made three categories for the fully immunized children:

1. Complete immunization before the children reach the age of one year, without considering the age of getting the vaccination and the interval of DPT and Polio:
There were 71 children of age 12 - 23 months (36%) included in this category.

2. Complete immunization before the children reach the age of one year, which got the measles at the age of nine month to 12 month, without regarding the age when they got other vaccination and the interval of DPT and Polio.
There were 44 children of age 12 - 23 months (23%) included in this category.

3. Complete immunization before the children reach the age of one year, which got the measles vaccination at the age of 9 - 12 month,

the interval of DPT and Polio, 3 to 6 weeks, without considering the age they got BCG.
There were 23 children of age 12 - 23 months (12%) included in this category.

In the baseline survey the fully immunized, which included in the first category of this final survey was 18,7%. In the baseline survey the number of children age 12 - 23 months were only 91, and they collected the data only from KMS cards. In this final survey the number of children age 12 - 23 months were 191, while the data were collected from KMS cards and Yellow book.

The data seems to indicate that the Department of Health's campaign to achieve universal child immunization was able to reach and increase the number of children who have never been immunized before, but the drop out is still high. It needs more campaign to get complete immunization, in terms of age, interval and the age when the child got the immunization.

MATERNAL CARE

24 of 239 mother interviewed (10%) had Maternal Health cards, while 28 mothers said that they had lost the Maternal Health cards.
18 of 24 mothers (75%) who had Maternal Health cards had at least two TT injection on their Maternal Health Card. 9 mothers had one TT injection (25%).
PC1 had printed and distributed 35,000 Maternal Health Cards to all Health Center in the area of CS VII project, but it seems that not all the cards had been distributed to the mothers. The national target rate for women fully immunized with TT injection is 80% by the end of 1994. In the baseline survey only two women had Maternal Health Cards, because in that year a program to distribute the Maternal Health Cards was just beginning.

Of the mothers who were using contraceptives, 30,9% using pills, 36,4% using hormone injection, 7,3% using norplant and 7,3% using IUD.

66% of mothers surveyed stated that a pregnant women should see the health professional during the first trimester of pregnancy, while 19,5% of the mothers said during the second trimester.

73,2% of mothers surveyed stated that they visited either Hospital, Health Center or clinic at least once during their pregnancy for antenatal care. This is the indication that Health Center or Posyandu is very important in delivering health services in the communities.

49,8% of mothers surveyed stated that trained TBA helped them at delivery, while 25,1% said that health professional (doctor, mid-wife nurse) attended their deliveries. The national target by the end of year 1994 is to have 50% of all births attended by health

professional. The national program to provide midwife-nurse in every villages is still being implemented and to achieve the target of 50% of all births attended by health professional needs time.

VI. LIMITATION

Many mothers were not at home at the time of interview, it may be they are at the rice field or go to another village. In this case the interviewer continued to the next house and did not return.

For immunizations, the surveyor collected data from the children's Road to Health Card (KMS) and Yellow book. In order to determine whether the children received the immunizations on time, the dates of the immunization had to be written on the cards. The problems with this methodology is apparent, sometimes the cards were misplaced or lost making assessment difficult.

VII. CONCLUSION

The result obtained from the survey showed that some targets of CS VII project had been achieved although the results are still lower than the target of Ministry of Health. The increase number of mothers who had attended by trained TBA and health worker at their delivery showed that the program of training TBa succeeded. PC1 had trained 1431 TBAs during CS VII project and more than 700 TBAs in the CS IV project, which included more than 50% of TBAs in the project area. I believe that the role of PC1 in this program is very strong.

While some targets were achieved, the children who received all doses of vaccination at the correct time are still low. MOH personnel doubt the results, because the report from Health Center showed more than 80% of children received complete immunization. A more thorough survey need to be done to clear this difference.

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APPENDIX 1

Survey questionnaire

a. English and Indonesian translation
b. Immunization questionnaire

PVO/COUNTRY IDNUM: _____

PVO Child Survival Knowledge & Practice Questionnaire
Project Concern International/Indonesia - Riau

All questions are to be addressed to the mother (women 15-49 years old) with a child under two (less than 24 months old)

Interview date __/__/91 (dd/mm) Reschedule interview __/__/91 (dd/mm)
Interviewer name _____
Supervisor _____

1. Name and age of the mother

   Name _____ Age (years) _____

2. Name and age of the child under two years old

   Name _____

   Birth date__/__/__ (dd/mm/yy) Age in months_____

   DESA _____ RT/RW _____

Mother's Education/Occupation

3. What was the highest educational level you attained?
   1. none [ ]
   2. primary does not read [ ]
   3. primary reads [ ]
   4. secondary & higher [ ]

4. Do you work away from home?
   1. yes [ ]
   2. no [ ]

5. Do you do any "income generating work"?
   (multiple answers possible; record all answers)
   a. nothing [ ]
   b. handicraft, weaving, rugs, etc [ ]
   c. harvesting, fruit pickers [ ]
   d. selling agricultural products [ ]
   e. selling foods, dairy products [ ]
   f. servant/services [ ]
   g. shop keeper, street vendor [ ]
   h. salaried worker [ ]
   i. other (specify) _____ [ ]

6. Who takes care of (name of child) while you are away from home?
(multiple answers possible; record each one)

a. mother takes child with her [ ]
b. husband/partner [ ]
c. older children [ ]
d. relatives [ ]
e. neighbors/friends [ ]
f. maid [ ]
g. nursery school [ ]

Breastfeeding/Nutrition

7. Are you breastfeeding (name of child)?

1. yes [ ] ---> go to 9
2. no [ ]

8. Have you ever breast-fed (name of child)?

1. yes [ ]
2. no [ ] ---> go to 10

9. After the delivery, when did you breast-feed (name of child) for the first time?

1. during the first hour after delivery [ ]
2. from 1 to 8 hours after delivery [ ]
3. more than 8 hours after delivery [ ]
4. do not remember [ ]

10. a. Are you giving (name of child) water (or herbal teas)?

1. yes [ ]
2. no [ ]
3. doesn't know [ ]

b. Are you giving (name of child) bottle milk?

1. yes [ ]
2. no [ ]
3. doesn't know [ ]

c. Are you giving (name of child) semisolid foods such as gruels, porridge or semolina?

1. yes [ ]
2. no [ ]
3. doesn't know [ ]

d. Are you giving (name of child) fruits or juices?

1. yes [ ]
2. no [ ]
3. doesn't know [ ]

e. Are you giving (name of child) carrot, squash, mango or papaya?
   1. yes [I
   2. no [ ]
   3. doesn't know [ ]

f. Are you giving (name of child) leafy green vegetables, such as spinach?
   1. yes [I
   2. no [ ]
   3. doesn't know [ ]

g. Are you giving (name of child) meat or fish?
   1. yes [ ]
   2. no c I
   3. doesn't know [ ]

h. Are you giving (name of child) lentils, peanuts, or beans?
   1. yes c 3
   2. no [ ]
   3. doesn't know [ ]

i. Are you giving (name of child) eggs or yogurt?
   1. yes c 3
   2. no [ ]
   3. doesn't know [ ]

j. Are you adding leafy green vegetables, such as spinach, to (name of child)'s food?
   1. yes [ ]
   2. no c I
   3. doesn't know [1

k. Are you adding honey or sugar to (name of child)'s meals?
   1. yes c 3
   2. no [ ]
   3. doesn't know [I

l. Are you adding fat (lard) or oil to (name of child)'s meals?
   1. yes [1
   2. no [ ]
   3. doesn't know [ ]

m. Are you adding iodized salt (local name) to (name of child)'s meals?
   1. yes c I
   2. no [ ]
   3. doesn't know [I

Health workers believe that it is very important to breastfeed during the first years of life.

11. What can a mother do in the baby's first three or four days of life to keep on breastfeeding?
(multiple answers possible; record all answers)

a. doesn't know [ ]
b. breastfeed as soon as possible after delivery (don't discard colostrum) [ ]
c. avoid bottle feeding of baby [ ]
d. frequent sucking to stimulate production [ ]
e. care of breasts, nipples [ ]
f. other (specify) _____ [ ]

12. What can a mother do in the first four months in a baby's life to keep on breastfeeding?
(multiple answers possible; record all answers)

a. doesn't know [ ]
b. exclusive breastfeeding during the first four months [ ]
c. avoid bottle feeding of baby [ ]
d. frequent sucking to stimulate production [ ]
e. relactation (mother can exclusive breastfeed again) [ ]
f. other (specify) _____ [ ]

13. When should a mother start adding foods to breastfeeding?

1. start adding between 4 and 6 months [ ]
2. start adding earlier than 4 months [ ]
3. start adding 6 months or later [ ]
4. doesn't know [ ]

14. What should those additional foods to breastfeeding be?
(multiple answers possible; record all answers)

a. doesn't know [ ]
b. add oil to food [ ]
c. give food rich in Vitamin A [ ]
d. give food rich in iron [ ]
e. other (specify) _____ [ ]

15. Which vitamin helps you prevent "night blindness"?

1. vitamin A [ ]
2. doesn't know or other [ ]

16. Which foods contain vitamin A to prevent "night blindness"?
(multiple answers possible; record all answers)

a. doesn't know or other [ ]
b. green leafy vegetables [ ]
c. yellow type fruits [ ]
d. meat/fish [ ]
e. breast milk [ ]
f. egg yolks [ ]

17. Does (name of child) have a KMS card?

1. yes	[ ]	(must see card)
2. lost card	[ ]	---> go to 21
3. no	[ ]	---> go to 21

18.

Look at the KMS card of the child, and record the following information: has the child been weighted in the last four months?

1. yes [ ]
2. no [ ]

19.

Look also at the KMS card, and indicate if there is a space to record vitamin A capsules

1. yes [ ]
2. no [ ] ---> go to 21

20.

If yes, record the dates of all vitamin A capsules given to this child in the space below

(dd/mm/yy)

1st __/__/__
2nd __/__/__
3rd __/__/__
4th __/__/__

Diarrheal Diseases

21. Has (name of child) had diarrhea during the last two weeks?

1. yes	[ ]	
2. no	[ ]	---> go to 26
3. doesn't know	[ ]	---> go to 26

...g (name of child)'s diarrhea did you breast-feed (read the choices to the mother).....

1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. stopped completely? [ ]
5. child not breastfed [ ]

23. During (name of child)'s diarrhea, did you provide (name of child) with fluids other than breast-milk..... (read the choices to the mother)

1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. stopped completely? [ ]
5. exclusively breastfeeding [ ]

24. During (name of child)'s diarrhea, did you provide (name of child) with solid/semisolid foods ..... (read the choices to the mother)

1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. stopped completely? [ ]
5. exclusively breastfeeding [ ]

25. When (name of child) had diarrhea, what treatments, if any, did you use? (multiple answers possible; record all answers)

a. nothing [ ]
b. ORS sachet [ ]
c. sugar-salt solution [ ]
d. infusions or other fluids [ ]
e. anti-diarrhea medicine or antibiotics [ ]
f. other specify _____ [ ]

26. What signs/symptoms would cause you to seek advice or treatment for (name of the child)'s diarrhea? (multiple answers possible; record all answers)

a. doesn't know [ ]
b. vomiting [ ]
c. fever [ ]
d. dry mouth, sunken eyes, decreased urine output (dehydration) [ ]
e. diarrhea of prolonged duration (at least 14 days) [ ]
f. blood in stool [ ]
g. loss of appetite [ ]
h. weakness or tiredness [ ]
i. other (specify) _____ [ ]

27. What are important actions you should take if (name of child) has diarrhea?
(multiple answers possible; record all answers)

a. doesn't know [ ]
b. take the child to the general hospital/health center [ ]
c. give the child more to drink than usual [ ]
d. give the child smaller more frequent feeds [ ]
e. withhold fluids [ ]
f. withhold foods [ ]
g. other (specify) _____ [ ]

28. What are important actions a mother should take when a child is recovering from diarrhea?
(multiple answers possible; record all answers)

a. doesn't know [ ]
b. give the child smaller more frequent feeds [ ]
c. more foods than usual [ ]
d. give foods with high caloric content [ ]
e. other (specify) _____ [ ]

Immunizations

29. Has (name of child) ever received any immunizations?

1. yes [ ]
2. no [ ]
3. doesn't know [ ]

30. At what age should (name of child) receive measles vaccine?

1. specify in months [__/__]
2. doesn't know [ ] (99)

31. Can you tell me the main reason why pregnant women need to be vaccinated with tetanus toxoid vaccine?

1. to protect both mother/newborn against tetanus [ ]
2. to protect only the woman against tetanus [ ]
3. to protect only the newborn against tetanus [ ]
4. doesn't know or other [ ]

32. How many tetanus toxoid injections does a pregnant woman need to protect the newborn infant from tetanus?

1. one [ ]
2. two [ ]
3. more than two [ ]
4. none [ ]
5. doesn't know [ ]

33.

If the child has a KMS card, indicate if there is a space to record vitamin A capsules
If yes, ---> go to 20 and record the dates of all vitamin A capsules given to this child in boxes 19 and 20

MATERNAL CARE

35. Do you have a maternal health card?
    1. yes (must see card) [ ]
    2. lost it ---> go to 39 [ ]
    3. no ---> go to 39 [ ]

36. Look at the maternal health card and record the number of TT vaccinations in the space below:
    1. one [ ]
    2. two or more [ ]
    3. none [ ]

37. Does the card have space to record ante-natal care visits?
    1. yes [ ]
    2. no [ ]

38. If, yes, record whether the mother ever made any ante-natal visit?
1. one or [ ]
2. two or more [ ]
3. none [ ]

39. Are you pregnant now?
1. yes [ ] ---> go to 43
2. no [ ]

40. Do you want to have another child in the next two years?
1. yes c 3 ---> go to 43
2. no c 3
3. doesn't know c 1

41. Are you currently using any method to avoid/postpone getting pregnant?
1. yes [ ]
2. no c 3 ---> go to 43

42. What is the main method you or your husband are using now to avoid/postpone getting pregnant?
1. tubal ligation c 1
2. Norplant [ ]
3. injections [ ]
4. pill [ ]
5. IUD [ ]
6. barrier method/diaphragm [ ]
7. condom [ ]
8 foam/gel [ ]
9. exclusive breast-feeding [ ]
10. rhythm [ ]
11. abstinence [ ]
12. coitus interruptus [ ]
13. other [ ]

43. How soon after a women knows she is pregnant should she see a health professional (physician, nurse, midwife)? (probe for months)
1. first trimester, 1-3 months [ ]
2. second trimester, 4-6 months [ ]
3. last trimester, 7-9 months [ ]
4. no need to see health worker [ ]
5. doesn't know [ ]

44. What foods are good for a pregnant woman to eat to prevent pregnancy anemia?
(multiple answers possible; record all answers)
a. doesn't know [ ]
b. proteins rich in iron (eggs, fish, meat) [ ]
c. leafy green vegetables, rich in iron [ ]
d. other (specify) _____ c I

45. How much weight should a woman gain during pregnancy?

1. 10-12 kilos [ ]
2. gain weight of baby [ ]
3. doesn't know [ ]
4. other (specify) _____ [ ]

46. When you were pregnant with **(name of child)** did you visit any health site (dispensary/health center, aid post) for pregnancy/prenatal care?

1. yes [ ]
2. no [ ]

47. During (name of child)'s pregnancy, was the amount of food you ate.....

(read the choices to the mother)

1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. doesn't know [ ]

48. At the delivery of (name of child), who tied and cut the cord?

1. yourself [ ]
2. family member [ ]
3. traditional birth attendant [ ]
4. health professional (physician, nurse or midwife) [ ]
5. other (specify) _____ [ ]
6. doesn't know [ ]

KUESTIONER IMUNISASI

UNTUK MENCATAT DATA IMUNISASI BAGI ANAK YANG BERUSIA 11 - 23 BULAN.

Tgl.Wawancara : / /

Nama Pewawancara :

Nama Penyelia :

ıor Kluster

ɜ a

ımatan :

NAMA IBU	NAMA ANAK	TGL.LAHIR ANAK (Catat)	KMS (Ada/Tidak)	CATATAN LAIN (Catat)	TANGGAL PENCATATAN IMUNISASI								IMUNISASI LENGKAP (Ya/Tidak)
					BCG	POLIO 1	POLIO 2	POLIO 3	DPT 1	DPT 2	DPT 3	CAMPAK–	

DAERAH SURVEY AKHIR PKHA VII
PCI - RIAU

NO	KABUPATEN	KECAMATAN	D E S A	JUMLAH PENDUDUK
1	BENGKALIS	Tanah Putih	Pujud	10,776
2			Ujung Tanjung	1,333
3		Kubu	Pasir Putih	8,807
4			Simpang Kanan	8,176
5			Panipahan	14,044
6		Bangko	Bangko Jaya	11,065
7			Suak Air Hitam	94
8			Bagan Kota	9,244
9			Raja Bejamu	1,973
10		Rupat	Tanjung Kapal	3,179
11			Makeruh	1,424
12	INDRAGIRI HULU	Kuantan Mudik	Pulau Mungkur	985
13		Sengingi	UPT II SKP S Suka Maju	2,128
14		Peranap	Pematang	2,470
15		Seberida	UPT Belilas III DK IV	747
16			UPT Ness II Sei. Babat	1,125
17		Benai	Pulau Ingu	1,054
18	INDRAGIRI HILIR	Enok	Sungai Rukam	6,199
19			Simpang Tiga	3,417
201		I Mandah	I Bekawan	4,260
211			Bente	3.093
221		I Kateman	Tagga Raia	25.816
23	K A M P A R	XIII Koto Kampar	Balung	820
24		Tandun	UPT IV Sungai Tapung	2,148
25			Ngaso	2,360
26		Tambusai	UPT III Tambusai	1,465
27		Kunto Darussalam	Kota Intan	1,3981
28		Panakahn Kuras	UPT Ukui I Air Hitam	6,120
29		Bunut	Tambun	961
30		Kuala Kampar	Teluk Meranti	1,912
JUMLAH PENDUDUK DAERAH SURVEY AKHIR PKHA vii				138,593

THE DEVISION OF FINAL SURVEY TEAM
PCI – RIAU

TEAM	SUPERVISOR	VILLAGE	SUBDISTRICT	DAYS
-	BENGKALIS			
A	Ismail Nasution	Pujud	Tanah Putih	10
		Ujung Tanjung	Tanah Putih	
		Pasir Putih	Kubu	
		Simpang Kanan	Kubu	
		Bangko Jaya	Bangko	
B	M. Saleh (PJKAB)	Panipahan	Kubu	13
		Suak Air Hitam	Bangko	
		Bagan Kota	Bangko	
		Raja Bejamu	Bangko	
C	Herlina	Tanjung Kapal	Rupat	7
		Makeruh	Rupat	
-	INDRAGIRI HULU			
A	Ida Roslina	Pulau Mungkur	Kuantan Mudik	8
		UPT II SKP S Suka Maju	Sengingi	
		Pulau Ingu	Benai	
B	Harliyanti (PJKAB)	Pematang	Peranap	9
		UPT Belilas III DK IV	Seberida	
		UPT Ness II Sei. Babat		
-	INDRAGIRI HILIR			
A	Afdal	Sungai Rukam	Enok	5
		Simpang Tiga		
B	Edy Guntung (PJKAB)	Bekawan	Mandah	9
		Bente		
		Taga Raja	Kateman	
–	KAMPAR			
A	Indro Wirasto (PJKAB)	Balung	XIII Koto Kampar	10
		UPT IV Sei. Tapung	Tandun	
		Ngaso		
		UPT III Tambusai	Tambusai	
		Kota Intan	Kunto Darussalam	
B	Yuprizal Putra	UPT Ukui I Air Hitam	Pangkalan Kuras	9
		Tambun	Bunut	
		Teluk Meranti	Kuala Kampar	

A:SURTEAM . IW 2

APPENDIX 3

Training Schedule

Jadwal dan Materi
Latihan Pewawancara Survey Akhir
PKHA VII PCI – Riau

NO,	WAKTU	MATERI	FASILITATOR				METODE
			BKS	INU	INI	KMP	
1	8.00–8.45	Latar Belakang Survey, Kegiatan PCI -Riau pada PKHA VII dan Maksud/Tujuan Survey	IN MS HL !	IDA EMI	EG AFD	IW YP	- Ceramah –Tanyajawab
2	8.45-9.15	Cara Menentukan Starting Point	sda	sda	sda	sda	–Ceramah –Tanyajawab
3	9.15–10.00	Penjelasan Kuesioner	sda	sda	sda	sda	-Ceramah –Tanyajawab
4	10.00–10.30	Istirahat / Snack	sda	sda	sda	sda	–
5	10.30-11.00	Penjelasan Kuesioner (lanjutan)					idem
6	11.00–12.30	Cara Mengisi Kuesioner dan Masahhnya	sda	sda	sda	sda	–Simulasi -Diskusi
7	12.30-14.00	Istirahat dan Makan Siang					–
8	14.00-16.00	Praktek Lapangan dan Pembahasan Temuan Lapangan	sda	sda	sda	sda	-Praktek lapangan - Diskusi
9	16.00-17.30	Penyusunan Rencana Survey - Jadwal / Wilayah Survey -Administrasi -Dana	sda	sda	sda	sda	-Diskusi

a:surmateri iw 2

APPENDIX 4

List of survey team

LIST OF SURVEY TEAM

SUPERVISORS

a.	YLJFRIZAL PUTRA	(PC1 staff)
b.	EDY GUNTUR SE	(PC1 staff)
c.	M. SALEH	(PC1 staff)
d.	INDRO WIRASTO SE	(PC1 staff)
e.	ISMAIL NASUTION	(PC1 staff)
f.	HARLIYANTI JHON SH	(PC1 staff)
g.	HERLINA SE	(PC1 staff)
h.	A F D A L	(PC1 staff)
i.	Ir. IDA ROSLINA	(PC1 volunteer)

SURVEYORS

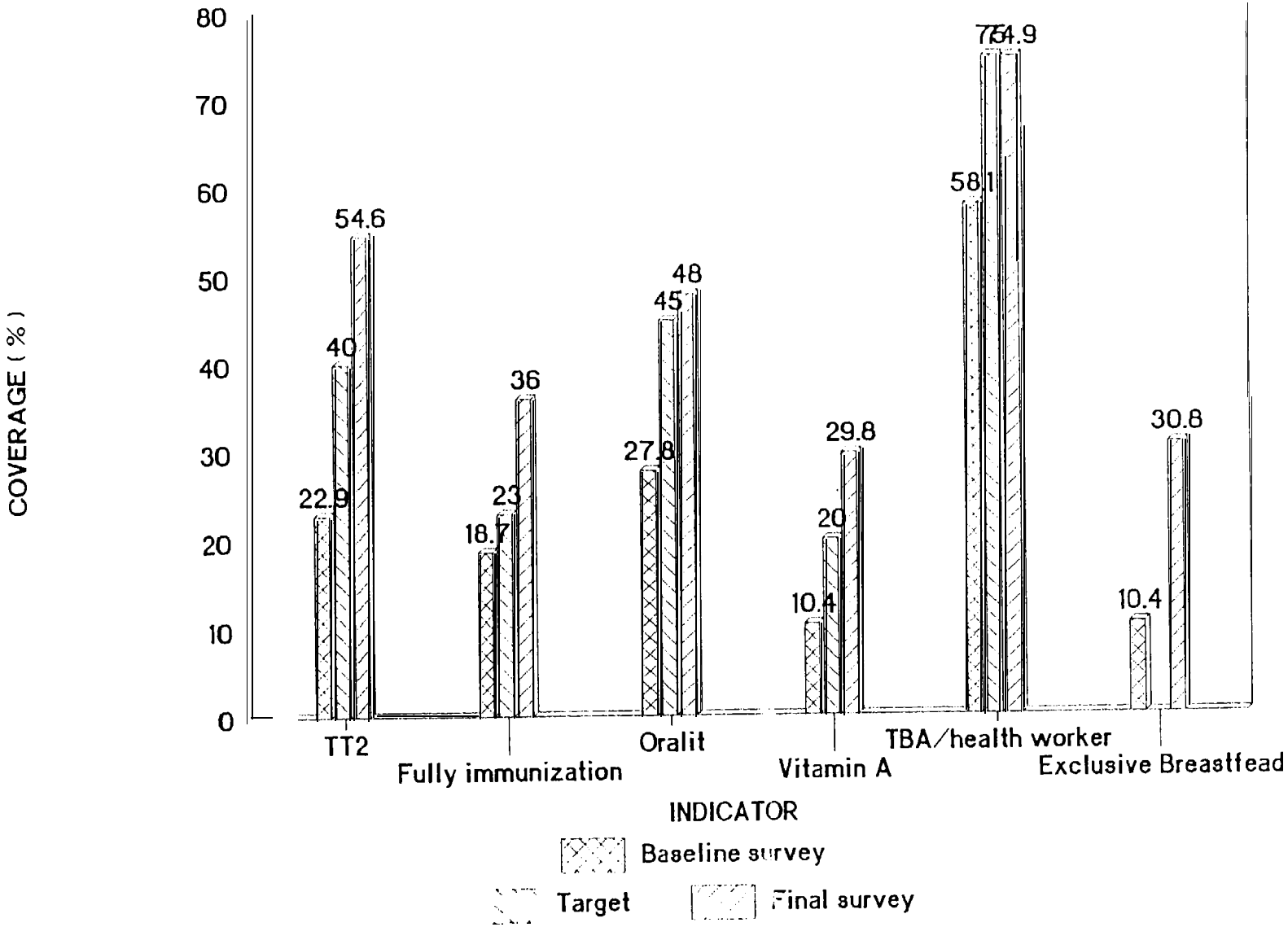
a.	MARJOKO SANTOSO Bsc	(MOH District of Bengkalis)
b.	IMAM SUBCHI Bsc	(MOH District of Benqkalis)
c.	ELM1 RIZAL	(MOH District of Bengkalis)
d.	S U R I P	(MOH District of Kampar)
e.	ALAMSYAH	(MOH District of Kampar)
f.	H E L M 1	(MOH District of Indragiri Hulu)
a-	GUSTIANDRI	(MOH District of Indragiri Hulu)
h.	RISKOMARA SKM	(MOH District of Indragiri Hilir)
i.	HAYANDI Bsc	(MOH District of Indragiri Hilir)

APPENDIX 5

Graph of indicator

RESULT OF CS VI

Project Concern International/Riau

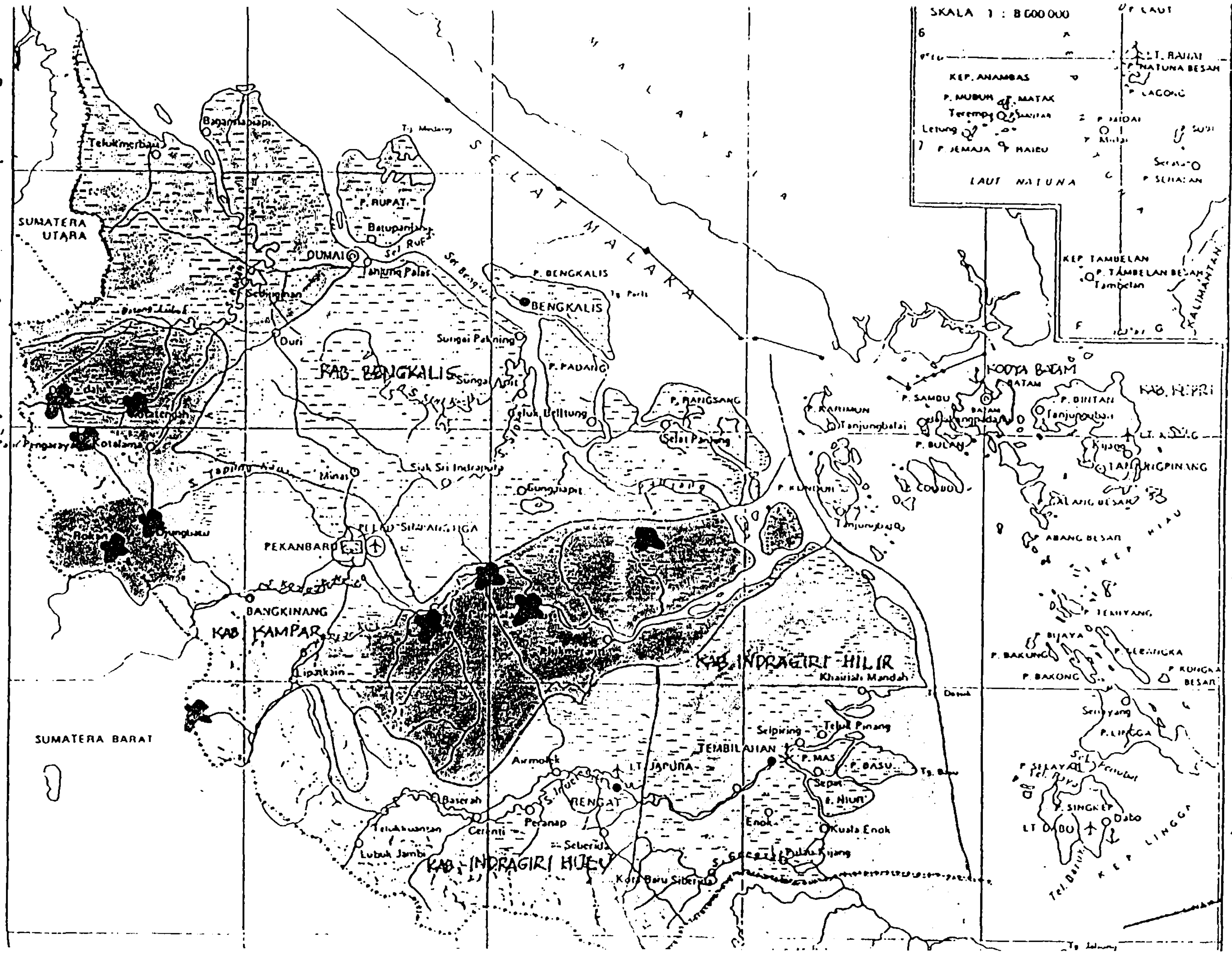


HASIL PROGRAM PKHA VII

No	Perinclan Sasaran	CS IV		CS VII		
		Baseline Survey	Final Survey	Baseline Survey	Sasaran Proposa	Final Survey
1	IMUNISASI I-r (PENGETAHUAN) (KMS)	20 %	36,7 %	22,9 %	40 %	54,6 % 32,5 %
2	IMUNISASI LENGKW	18,6 %	24,3 %	18,7 %	23 %	38%
8	ORALIT	26,3 %	30,3 %	27,8 %	45 %	48%
4	VITAMIN A			10,42 %	20 %	29,8 %
5	DITOLONG DUKUN/PETUGAS			58,1 %	75 %	74,9 %
6	EXCLUSIVE ASI <=4 BULAN			10,4 %		30,76 %
7	KMS ANAK					46,4 %
8	KMS IBU					10%
8	KB (IBU YANG TIDAK HAMIL)					46,9 %
10	KABUPATEN	7		4		
11	KECAMATAN	36		27		
12	PUSKESMAS	36		33		
13	DESA	175		439		
14	PENDUDUK			894174		
15	POKJANAL KECAMATAN			455		
16	POKJANAL DESA			1425		
17	KADER			700		
18	DUKUN BAYI			1491		
19	SMP			5		
20	SD			21		
21	GURU			56		
22	MURID			2222		

APPENDIX 6

Map of CS VII project


SKALA 1 : 8 000 000
SELAT MALAKA
SUMATERA UTARA
SUMATERA BARAT
KAB. BENGKALIS
KAB. KAMPAR
KAB. INDRAGIRI HILIR
KAB. INDRAGIRI HULU
KOTA BATAM
KAB. RIAU
DUMAI
BENGKALIS
PEKANBARU
BANGKINANG
RENGAT
TEMBILAHAN
P. RUPAT
P. BENGKALIS
P. PADANG
P. RANGSANG
P. BINTAN
P. SINGKEP
P. LINGGA
KEP. ANAMBAS
KEP. TAMBELAN
LAUT NATUNA
P. NATUNA BESAR
KALIMANTAN
Bagansiapiapi
Telukmerbau
Batupanjang
Tanjung Palas
Duri
Sungai Pakning
Minas
Gunungsahilan
Lipatkain
Pasir Pengaraian
Kotalama
Baserah
Cerenti
Peranap
Airmolek
Lubuk Jambi
Telukkuantan
Selpiring
Teluk Pinang
P. MAS
P. BASU
Kuala Enok
Enok
Pulau Kijang
Khairiah Mandah
Tanjungbalai
Tanjungpinang
P. BULAN
P. SAMBU
BATAM
P. KUNDUR
P. BAKONG
P. SELAYAR
Dabo
Tambelan
P. TAMBELAN BESAR
Terempa
Letung
P. JEMAJA
P. MUBUR
P. MATAK
KEP. LINGGA
KEP. RIAU